



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Maryland**

**Application for 2009  
Annual Report for 2007**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. Assurances and Certifications**

The required assurances and certifications have been signed by Ms. Bonnie S. Birkel, Director of the Center for Maternal and Child Health and housed in the Center for Maternal and Child Health's central offices. The assurances and certifications will be made available to the Maternal and Child Health Bureau upon request.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

A notice was placed in the Maryland Register inviting the public to review and comment on the 2008 application. Thus far, no comments have been received in response to the notice. Notices announcing an opportunity for public comment on the Title V application were placed in local weekly newspapers distributed throughout the State. The public is invited to review a summary MCH plan for 2008 and to comment on the State's current MCH priorities and performance measures through a web based survey. The survey tool will remain available for public comment throughout the coming year. Survey results will be reviewed and compiled bi-monthly to assist in identifying emerging MCH needs. Comments and recommendations generated by the survey will be considered for incorporation into MCH needs assessment and planning efforts over the next two years. Comments will be summarized and included in next year's application. Links to both the needs assessment and the 2009 application will be available on both the CMCH and OGCSHCN Web sites.

Parents of CSHCN from The Parents' Place of Maryland were participants in preparation and review of the CSHCN portions of the block grant application.

## II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

Updates to Needs Assessment for CYSHCN

There are a number of new data sources available related to CYSHCN since the 2005 needs assessment. Some interesting/important findings from selected data sources are described below.

#### Health Care Transition Survey of Pediatricians

Kennedy Krieger Institute, in partnership with the Office for Genetics and Children with Special Health Care Needs (OGCSHCN), conducted a brief survey by mail of pediatricians to assess their current practices and needs related to supporting the health care transition process for CYSHCN in their care. The survey was inadvertently sent to Maryland family practitioners as well as pediatricians, with no way to distinguish the responses from the two groups. This obviously limits the data somewhat, as we would not expect that family practitioners would transition their YSHCN. The overall response rate was 12.5% out of 2500 surveys mailed. Key findings:

- Areas of relative self-reported strength for pediatric primary care providers were in the areas of keeping comprehensive medical summaries, meeting privately with adolescents for part of the visit, and providing age-appropriate and developmentally-appropriate anticipatory guidance
- Some of the areas of greatest weakness were found in creating a written health care transition plan, ability to direct patients and their families to resources that facilitate transition, and assisting families with identifying health care providers who are comfortable caring for adults and collaborating with those providers
- Knowledge of health care resources, knowledge of educational and vocational resources, and time were the top 3 issues reported to impact pediatric primary care providers' ability to facilitate health care transition planning

#### Medical Home Survey of Respite Recipients

The local health departments, in partnership with OGCSHCN, distributed a brief survey by mail or in person to families of CYSHCN receiving funding for respite supported by OGCSHCN monies. The survey asked questions primarily about the quality of different aspects of care provided by the child's primary care provider. There were 455 responses with an unclear number of surveys distributed. Key findings:

- Very few families had ever heard the term "medical home"
- Areas of parent-reported strength for their child's PCP: accessibility, components of compassionate and culturally competent care
- Areas of parent-reported weakness in their child's PCP were in aspects of health care transition, shared decision-making, provision of information about public resources, care plan development, and coordination/communication with other providers

#### Survey of Adult Primary Care Providers Regarding Sickle Cell Disease

Transition planning for children identified with sickle cell disease (SCD) through newborn screening has been complicated by the paucity of services for adult SCD patients and the scarcity of physicians willing to accept new patients with SCD. The OGCSHCN distributed a survey to 3520 internists, family practitioners and general practitioners to ask what would help them to see more SCD patients. The overall response rate was 12.9% but only 22% (97 responses) were informative. Key findings:

- 24% said they did not want to see SCD patients.
- Of those willing to see SCD patients: 38% asked for free case management services, 30% for higher reimbursement, 28% for a 24/7 on call SCD specialty consultant, 27% for convenient relevant CME, 27% for an SCD center within reach, 24 % for a pain management specialist on call and 17% for a day hospital within reach.

## Updates to the Needs Assessment for the Maternal and Child Health Programs

### Babies Born Healthy Initiative

The Center for Maternal and Child Health initiated the Babies Born Healthy Program to improve perinatal health through a comprehensive approach. The design and implementation of activities for the Babies Born Healthy program were completed after thorough quantitative and qualitative data analysis. Vital statistics data were analyzed by maternal characteristics, including race, educational attainment, and maternal age. Leading causes of infant death also were analyzed. Causes of infant mortality include premature birth, congenital anomalies, Sudden Infant Death Syndrome, and maternal complications.

Maternal behaviors also are known to be associated with poor pregnancy and birth outcomes. An increasing percentage of women in Maryland receive late (after 20 weeks gestation) or no prenatal care. Additionally, pre-pregnancy health is important for good pregnancy outcomes, yet approximately 42 percent of births in Maryland are not planned. Furthermore, 47 percent of Maryland women of childbearing age are overweight or obese, and 20 percent of Maryland women of childbearing age smoke.

Qualitative data also were used to provide insights into the factors associated with infant mortality. Specifically, Fetal and Infant Mortality Review (FIMR) and Key Informant Interviews have yielded information for targeting interventions. Fetal and Infant Mortality Review are a confidential and anonymous review of individual cases of fetal and infant loss to identify needs and opportunities for change in community systems that will improve perinatal outcomes. Through this process, needs related to preconception and reproductive health, preterm labor prevention, infant care, healthy pregnancy behaviors, substance abuse cessation, and bereavement support have been realized. Additionally, MCH conducted a needs assessment of the leadership and programmatic concerns in Maryland related to infant mortality through interviewing experts from obstetrics, pediatrics, nursing, social work, and public health, which became known as Key Informant Interviews. The Key Informants' revealed the need for improved data, emphasis on preconception health, and attention to racial health disparities.

***//2009/ CMCH funded a needs assessment to determine the need for expansion of Baltimore City Healthy Start Inc. outreach and family support services in Baltimore City. The federally funded Baltimore City Healthy Start project provides a range of enabling services to reduce adverse birth outcomes in high risk areas of the City. The results of the needs assessment that included both qualitative and quantitative components demonstrated the need for expanded services in four neighborhoods in Baltimore City. The State is now partnering with Healthy Start Inc. to provide these services. //2009//***

### **III. State Overview**

#### **A. Overview**

According to the U.S. Census Bureau, Maryland was home to 5,558,058 residents in 2004. This included 374,578 young children under the age of five; 368,612 elementary school aged children between the ages of five to nine; 806,368 adolescents between the ages of ten to nineteen; and 366,452 young adults ages 20-24. Maryland is comprised of 23 counties and the City of Baltimore and is characterized by mountainous rural area in the Western part of the State, densely populated urban and suburban areas in the central and southern regions and flat rural areas on the Eastern Shore. The State borders West Virginia, Pennsylvania, Washington, D. C., Delaware and the Atlantic Ocean. Maryland has 9,837 square miles of land area, 623 square miles of inland waters and 1,726 square miles that constitute the Chesapeake Bay, the world's largest estuary. In 2004, Maryland ranked 19th in population and 6th in population density among the states (including the District of Columbia) with 541.9 persons per square land mile.

Maryland's population grew by 4.9% as compared to an overall U.S. growth rate of 4.3% between 2000 and 2004. Montgomery and Prince George's counties, both part of the Washington D.C. suburbs, accounted for the majority of this population growth. Conversely, the population of Baltimore City continued to decline, decreasing by 14% during this same time period. The majority of Maryland residents (75%) live in the two major metropolitan areas surrounding either Baltimore City or Washington D.C., while 11% live in Baltimore City and 14% reside three more outlying rural areas: Western Maryland, Southern Maryland and the Eastern Shore. The Baltimore-Washington D.C. combined Metropolitan Statistical Area constitutes the nation's fourth largest retail market.

/2007/ In 2005, Maryland's total population grew to 5,600,338. Since 2000, Maryland's population has grown by nearly 304,000 persons. Foreign immigration, particularly in the Washington, D.C. metropolitan area, accounts for a significant percentage of population growth. Population size within Maryland's 24 jurisdictions ranged from a low of 19,899 in Kent County to a high of 927,583 in Montgomery County. Many local health departments are directing increasing percentages of resources to address the increasing linguistic and cultural diversity of the State's population. In several instances, county budgets for translators and interpreters increased in recent years. //2007//

The State's 1,549,558 children and adolescents ages 0-19 represented 27.8% of Maryland's population in 2004. Senior citizens, aged 65 and over, represented 11.4% of the population. The median age was 36.9 years. An estimated 1.2 million women of childbearing age (ages 15-45) lived in Maryland in 2004. Between 1999 and 2004, an average of 73,463 babies were born each year. The state's birth rate has been declining overall as well as for most racial and ethnic groups.

Maryland is a diverse State and one that is becoming more diverse over time. With the exception of Western Maryland, the State's minority racial and ethnic populations are rapidly increasing and comprise a significant portion of the population of each geographic area. Racially, Maryland's population was distributed as follows in 2004: 64.5% were Caucasian, 29.1% were African American, 4.6% were Asian, 1.4% represented two or more races and less than one percent were American Indian or Native Hawaiian. As a whole, racial minorities comprised an estimated 35.5% of Maryland's population in 2004, up from 28% in 1990. Of the 2.0 million racial minority residents in Maryland, African Americans represented 82% in 2004. Hispanics, the fastest growing ethnic minority in Maryland, represented 5.4% of the total State population in 2004. Compared to the national average, Maryland has a greater proportion of African-Americans (two times of the national average) and a lower percentage of Hispanics (one third of the national average).

***/2009/ The number of minorities in Maryland continues to grow as the State's white***

**population decreases. Minorities represented 42% of the State's 2007 population of 5.6 million. Latinos continue to be the fastest growing racial/ethnic group, representing over 6 percent of the State's 2007 population. Racial/ethnic minorities (52% in 2006) now represent a majority of the babies born in Maryland. //2009//**

Maryland's undocumented immigrant population has continued to increase. Between 2000 and 2004, the numbers of undocumented immigrants in Maryland are estimated to have doubled from 120,000 to approximately 250,000 (Pew Hispanic Center, Estimates of the Size and Characteristics of the Undocumented Population). A large percent of undocumented residents are women, and about one in six are children. While nationally, 57% of this population migrates from Mexico, Maryland's Hispanic immigrants are predominantly from the South and Central Americas and the Caribbean Islands. The increasing numbers of undocumented women and children, coupled with state budgetary constraints, has strained the ability of local health departments to provide and maintain services for uninsured MCH populations.

**//2009/ The 2008 Maryland Legislature passed a bill establishing a Commission to study the Impact of Immigrants in Maryland including a demographic profile of the population as well as an analysis of the fiscal impact of immigration on the State. A report is due to the Governor by January 2011. //2009//**

U.S. Census data for Maryland indicate that both the total number of poor persons and the poverty rate rose between 1990 and 2000. The Census reported that 438,700 Marylanders (8.3% of the total population) lived in poverty in 1999, however Maryland's poverty rate for 2003 was 10.4%. Still, Maryland is comprised of some of the wealthiest communities and jurisdictions in the nation. Maryland continues to be one of the wealthiest states in the nation with per capita, median and mean household incomes that consistently rank within the top five nationally. Maryland ranked as the nation's second richest state with a median household income of \$57,218 in 2003 according to the Census Bureau's American Community Survey.

Nationally, Maryland's poverty rate placed it at the sixth lowest in the nation in 2004 (American Community Survey). Poverty rates vary by race/ethnicity and jurisdiction in Maryland. For example, the poverty rate for African Americans is two to three times higher than the rate for Caucasian Americans. The 2003 Governor's Commission on Poverty noted that the state has several "areas of concentrated poverty" particularly in Baltimore City, in Western Maryland and on the Eastern Shore. These areas are characterized by high unemployment, high crime and violence, teen parenting, a lack of father figures, low performing schools and deteriorating and physical environments. Children living in these communities are increased risk for a host of poor health outcomes.

**//2007/ Nationally, according to the American Community Survey for 2004, child poverty rates in the states ranged from a high of 33.9% in Washington, D.C. to a low of 9.7% in New Hampshire. Maryland had the fifth lowest child poverty rate (11.4%) in 2004. //2007//**

While the majority of regions in Maryland experienced an economic boom during the 1990's, the Eastern Shore and Western Maryland experienced a decrease in their economic prosperity that has continued in the new millennium. By jurisdiction, the poverty rate for individuals ranged from a low of 3.8% in Carroll County to a high of 22.9% in Baltimore City in 1999. The poverty rate for children under the age of 18 stood at 10.3% statewide in 1999 and ranged from a high of 30.6% in Baltimore City to a low of 3.8% in Howard County.

Among all states, Maryland's workforce is one of the best educated. Over a third of Maryland's population aged 25 and older held a bachelor's degree or higher in 2003. More than 146,455 businesses employ 2.29 million workers. Seventy two percent of people employed were private wage and salary workers; 23% were federal, state or local government workers; and 5 percent were self-employed in 2003. Health care represents a \$26.5 billion industry in Maryland with per capita spending on health care reaching \$4,811 in 2003.

In spite of Maryland's affluence and many positive attributes, health indicators for the State remain mixed. In the latest (2005) Annie E. Casey Foundation ranking of states on child well-being, Maryland ranked 19th on 10 indicators of child well-being. On the positive side, as the state's latest needs assessment report shows, fewer women are smoking during pregnancy and more are initiating breastfeeding in the early postpartum period. Teen birth as well as child and adolescent death rates continue to decline. More children are being screened for lead exposure and fewer are being found with elevated blood lead levels. There are fewer uninsured children and more young children are being fully immunized. Fewer adolescents are smoking and juvenile arrests for violent crimes are down.

/2007/ In the 2006 Kids Count Report, Maryland's ranking slipped to 23rd. A rise in the infant mortality rate and a high teen death rate partially accounted for the slippage. On the positive side, the Report noted improvements in five of the ten survey areas including decreases in child deaths and high school dropout rates. //2007//

***/2009/ Maryland's ranking improved to 19th in the 2008 Kids Count Report. Between the 2006 and 2007 Reports, improvements were reported in infant, child and adolescent death rates. //2009//***

One area of continuing concern is the state's infant mortality rate. Maryland's infant mortality rate at 8.1 infant deaths per 1,000 live births in 2003 remains one of the highest in the nation. The state's infant mortality rate increased by 7% between 2002 and 2003 and current projections are that the rate has risen even higher in 2004. The Title V Program is currently conducting a review of infant deaths in the state and will report the findings in next year's application. Significant racial disparities remain in state with African Americans continuing to have significantly poorer perinatal outcomes than mothers and babies in other racial and ethnic groups. Maryland has identified the elimination of health disparities as a priority.

/2007/ The State's infant mortality rate rose again in 2004 to 8.5 deaths per 1,000 live births. The Title V Program used a linked dataset to investigate a statistically significant increase in deaths among African American infants in the Baltimore Metropolitan area between 2002 and 2003. The review revealed that need to improve access to preconception and interconception health services. For the seventh year in a row, the State's percentage of women receiving early prenatal care declined, lowering to 82.3% in 2004. Continuing concerns about the State's worsening perinatal outcomes led to the appropriation of funding for a new legislative initiative in 2006. The Babies Born Healthy Initiative will expand existing public health partnerships to reduce infant mortality. //2007//

/2008/ Infant mortality declined to a rate of 7.3 deaths per 1,000 live births in 2005. However, the racial gap in rates continued to worsen. The 2007 Legislature appropriated an additional 1.0 million to address infant mortality; however, part of this increase was lost during recent budget cuts brought on by a State fiscal crisis. //2008//

***/2009/ Infant mortality increased to a rate of 7.9 deaths per 1,000 live births in 2006. Additional funding was appropriated by the 2008 General Assembly to support the Babies Born Healthy Initiative. This was done in spite of the State's tight fiscal situation. //2009//***

Another area of concern is the growing number of uninsured Marylanders, particularly within the adult population. Over 740,000 Marylanders lacked health insurance coverage in 2002-2003. An estimated 140,000 of the state's uninsured were children between the ages of 0-18. Between 2001-2002 and 2002-2003, the state's uninsured non-elderly population increased by 60,000 while the numbers of uninsured children declined by 10,000. The state's MCHP program which provided insurance coverage to 150,643 children at some point during FY 2004 is partially credited with the decline in uninsured children. Black (13%), Hispanic (24%) and Asian (15%) children were three to six times more likely than White children (4%) to be uninsured.

The non-elderly uninsured rate was 15.3%, approximately two percentage points below the national average of 17.4% in 2002-2003. Fewer Maryland employers are offering insurance coverage as a benefit. The State's employment based coverage rate is estimated to have declined from 77 to 75 percent during 2000-2002 and continued falling to 72 percent in 2002-2003. Uninsured rates for non-elderly adults varied by race/ethnicity and were lowest for Whites (10%), followed by Blacks (17%), Asians (22%) and Hispanics (48%). Hispanics comprised 23% of the state's uninsured, but only 7% of the state's non-elderly population. Uninsured rates varied by poverty level and were highest for persons in families with incomes below the poverty level (39%). Only half of poor persons were enrolled in Medicaid.

***//2009/ Maryland's average annual uninsured rate among the nonelderly (under age 65) remained at approximately 15% in 2005-2006, with an average of 750,000 uninsured nonelderly residents. During a special session held in late 2007, the Maryland Legislature voted to enact legislation to expand Medicaid coverage for uninsured parents/caretaker relatives in households with incomes up to 116% of the federal poverty level, to expand coverage incrementally over a three year period to childless adults with incomes up to 116% of the federal poverty level and to establish a Small Employer Health Insurance Premium Subsidy Program. These provisions are expected to provide coverage for an additional 100,000 adult Marylanders. //2009//***

***//2009/ Nearly 12 percent of Maryland children were uninsured in 2005-2006. Several bills were introduced during the 2008 Legislative Session to facilitate increases in Medicaid and MCHP enrollment; however, none passed. //2009//***

***//2009/ Funding was appropriated this year for the Oral Health Safety Net Program. This Program is designed to improve access to dental care for low income children. Inadequacies in access to dental care became more apparent following the death of a young Prince George's County boy who developed complications due to an untreated dental problem. Based on the recommendations of a Dental Action Committee convened by Secretary Colmers, DHMH will receive funding to increase Medicaid dental reimbursement rates, provide oral health services in targeted communities, and to support school based dental health services. //2009//***

Injuries remain as the leading cause of child and adolescent deaths. Two major environmentally linked health conditions - asthma and lead poisoning -- continue as major causes of childhood morbidity. An estimated 153,000 Maryland children and adolescents have asthma. In 2003, 3,349 children were diagnosed with elevated blood lead levels (defined as a venous or capillary blood lead level  $\geq 10$  ug/dL). Obesity and obesity related illnesses such as type 2 diabetes are documented to be increasing among children and adolescents. The 2005 needs assessment reports that health providers and school health personnel are increasingly identifying depression and mental health disorders as problems among adolescents.

***//2009/ In 2007, the Maryland Legislature passed the Clean Indoor Air Act which prohibits smoking in most workplaces and resultantly reduces exposure to second hand smoke, a contributing factor to asthma for some Marylanders. //2009//***

Twenty of Maryland's 24 jurisdictions are currently either entirely or partially federally designated as medically underserved areas for primary care services. This occurs even though the ratio of primary care physicians to the population is higher in Maryland than the national average. Part of this higher representation is based on the high number of physicians employed by government research facilities, military and medical schools, in non-direct health care positions. Four of Maryland's twenty-four jurisdictions are currently classified as being underserved for dental health services/manpower and six jurisdictions are classified as underserved for mental health services. Federally qualified community health centers are located in 17 jurisdictions.

The Medicaid Program, known in Maryland as the Medical Assistance Program, serves as the major source of publicly sponsored health insurance coverage for children and adolescents. The Maryland Children's Health Program (MCHP) began operating as a Medicaid expansion program on July 1, 1998. The MCHP program expanded coverage for comprehensive health insurance for children up to the age of 19 with family incomes at or below 200 percent of the Federal Poverty Level (FPL). In 2001 Maryland initiated a separate children's health insurance program expansion, MCHP Premium. In FY 2004, 397,060 children and adolescents were enrolled in the Medicaid Program at some point during the year, while 150,643 were enrolled in MCHP. MCHP also provides insurance coverage for pregnant women with incomes between 185% and 250% of the federal poverty level. In FY 2004, Medicaid covered hospital delivery costs for approximately one-third of Maryland births.

More detailed MCH-related health status indicators are reported on in the other Narrative Sections and/or the Health Status Indicator Section. Emerging health trends, problems, gaps and barriers are also identified in the 2005 Needs Assessment Report.

#### State Health Agency Priorities

The mission of the Maryland Department of Health and Mental Hygiene is to protect and promote the health of the public by creating healthy people in healthy communities; to strengthen partnerships between state and local governments, the business community and all health care providers in Maryland; and to build a world class organization grounded in the principles of quality and learning, accountability, cultural sensitivity and efficiency.

Mr. S. Anthony McCann and Dr. Michelle Gourdine were appointed Secretary and Deputy Secretary for Public Health Services, respectively in FY 2005. Secretary McCann has stated that improving quality within the health care system is his priority for the next 6 years. Dr. Gourdine, the former Baltimore County Health Officer, has indicated that two of her top priorities are succession planning (developing the next generation of public health leaders) and public health prevention.

/2008/In November 2006, Marylanders elected a new democratic governor, the former Mayor of Baltimore City, the Honorable Martin O'Malley. Anthony Brown was chosen as his running mate for Lieutenant Governor. Governor appointed John M. Colmers, the former director of the Maryland Health Care Commission to replace S. Anthony McCann as the new Health Secretary. Dr. Gourdine remains as the Deputy Secretary for Public Health Services. Reforming the health care system and reducing the numbers of uninsured Marylanders are priorities for the current administration. //2008//

***/2009/ Secretary Colmer's priorities include expanding health insurance coverage, improving the quality of health care services and controlling health care cost growth. Governor O'Malley recently created the Maryland Health Quality and Cost Council through an Executive Order. This Council which is co-chaired by Secretary Colmers and Lieutenant Governor Brown will facilitate collaboration and make recommendations on health care quality improvement and cost containment initiatives across the public and private sectors. //2009//***

***/2009/ Dr. Michelle Gourdine left State service in February 2008 and her replacement is currently being sought. The current acting Deputy Secretary is Ms. Arlene Stephenson who previously held this position under a different administration. //2009//***

The elimination of health disparities remains as a DHMH priority. Objectives to address health disparities within the State's Health Improvement Plan for 2010. The Maryland General Assembly passed legislation in 2003 requiring the DHMH to develop and implement a plan to reduce health care disparities based on race/ethnicity, gender and poverty. The 2004 Maryland

General Assembly passed legislation establishing an Office of Health Disparities and Minority Health in the Department of Health and Mental Hygiene. This Office which is headed by Dr. Carleissa Hussein, sponsored the sponsored two statewide conferences on health disparities and is currently finalizing a state's health disparities plan.

//2007/ A bill (HB 851) was passed by the State legislature in 2006 requiring the OGCSHCN to work with the Office of Health Disparities and Minority Health, to formulate a plan for improving services for adult patients with sickle cell disease, drawing on the OGCSHCN's experience with lowering the mortality from sickle cell disease in the pediatric population. This is a transition issue for the OGCSHCN since the oldest sickle cell disease patients identified through newborn screening will turn 21 years old this month. //2007//

//2008/ The plan to improve services for adults with sickle cell disease (SCD) was formulated and the required report submitted to the legislature. In response a bill, HB793, was introduced with the intent of providing funding to implement the plan. The plan included the development of a day hospital at the only clinic in the State (at Johns Hopkins) dedicated to adult sickle cell disease patients; the development of an outreach case management network with nurse practitioners/ physician assistants providing home visiting and consultative services in primary care provider's offices and emergency rooms; telemedicine and outreach clinics; a 24/7 on call consultation service; an abbreviated electronic medical record available on line for all patients; a voluntary patient registry; strengthening patient support groups; a provider education web site with standard treatment protocols for health maintenance, emergency room management and the use of hydroxyurea; and publicizing the Employed Individuals with Disabilities Medicaid buy-in program. Unfortunately, because of the State structural budget deficit, the bill, as passed, only provided for a steering committee to strengthen stake holder partnerships, do some provider and patient education and to seek grant or other funding to carry out the rest of the plan. The OGCSHCN will work with the steering committee to accomplish as much as possible. //2008//

***//2009// The Statewide Steering Committee on Services for Adults with SCD was established with all the constituencies specified in the bill represented. The Committee has clearly succeeded in establishing institutional and community partnerships and a Statewide network of stakeholders. However, without funding, the other accomplishments are largely the accomplishments of individual groups of members, although these activities benefit from the support of the group. The Johns Hopkins Center for Adults with Sickle Cell Disease established a day infusion center through a creative partnership and sub-capitated funding arrangement with several MA managed care organizations. The Center opened in February 2008. Several grant applications were written. The NIH for a Comprehensive Sickle Cell Disease Center application submitted by the Johns Hopkins Medical Institutions was approved but not yet funded. MD Logix, a company specializing in electronic health information systems, developed a prototype sickle cell disease specific electronic health record/ workflow tracking system with funding from Small Business Innovative Research (SBIR) grants. Another MD Logix application to the NIH Institute of Nursing is pending. The Sickle Cell Disease Association of America submitted an unsuccessful application for a Patient Registry to the Agency for Health Care Research and Quality. Support group activities and numerous educational/ awareness activities, targetted to legislators, parent, patients, health care providers and the public, are ongoing. A workgroup including Blue Cross / Blue Shield of Maryland is working on strategies for implementing the Medical Home model of coordinated care for adult sickle cell disease patients.//2009//***

For the past three years, Department of Health and Mental Hygiene, the Family Health Administration and the Maternal and Child Health Offices have dealt continuously with budget, personnel and resource reductions. The state's public health system has faced severe budget reductions and other federal and state priorities, including Medicaid and emergency preparedness expenditures. Recently, programs within DHMH have been permitted to request and are receiving freeze exemptions for recent vacancies that have occurred because of

employees' retirement. While improvement in hiring is beginning to occur, past fiscal decisions have slowed the Department's ability to sustain and develop public health programs. It is anticipated that progress will be made but at a very slow rate.

/2008/ With the new gubernatorial administration and its concern for the structural budget deficit - \$1.4 billion in FY 2008, additional budget cuts are being made and freeze exemption requests are again being carefully scrutinized and sparingly granted, slowing the replacement of positions vacated by retirements.//2008//

The Family Health Administration's priorities will continue to focus on strengthening programs, as well as revitalizing public health data; building public health partnerships (with the academic centers, professional and advocacy groups, and others); and strengthening operational aspects of public health administration (e.g., budget, personnel, procurement, legislation, information technology). In addition, a major FHA focus will be on leadership development with special attention on developing and mentoring the next generation of public health leaders.

#### MCH/CSHCN Program Priorities

The Center for Maternal and Child Health Program priorities for the next four years are identified here:

Assuring access to family planning services continues as a priority. This includes assuring that the program maximizes resources, and minimizes costs while continuing to offer convenient no-cost/low-cost services through a diverse network of providers, to reach more women in need. This is to be done without sacrificing the current level of comprehensiveness or quality of services. Family planning services is one of the strategies for reducing infant mortality because women will be healthier and pregnancy will occur within a planned period to time.

Improving key indicators for the health of women and children (i.e., decreasing unintended pregnancy and fetal and infant mortality; and sustaining and increasing progress in teen pregnancy prevention). Reducing maternal, infant and child mortality and improving health outcomes will be achieved through the implementation of maternal mortality, fetal and infant mortality and child fatality review processes; the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS); and the continuation of local health department based home visiting and care coordination programs.

***/2009/ Further refinement of and implementation of the Babies Born Healthy Initiative will be a priority focus for the coming year. A Babies Born Healthy Summit is being planned for the Fall of 2008 to heighten awareness of the problem of infant death and sickness. The target audience includes legislators, health care providers, community groups and other key stakeholders. //2009//***

The state has developed a plan to eliminate elevated blood lead levels in children by 2010. CMCH will continue to work on activities to promote blood lead screening and collaborating with other agencies to reduce elevated blood lead levels in children under age 6.

Another priority focus will be on advancing new prevention priorities in the areas of environmental health (i.e., asthma) and healthy nutrition/physical activity to address obesity and overweight across the life span. CMCH is the recipient of a CDC asthma intervention grant and also is responsible for administering the legislatively mandated Asthma Control Program.

CMCH is also administering a MCHB funded early childhood grant. The Program will focus on developing a comprehensive approach to early childhood health that is fully integrated with broader, more comprehensive efforts aimed at healthy child development. The same approach will be used to develop a plan for improving adolescent health.

During the coming year, CMCH will also focus on refining the five year MCH strategic plan with input from local health departments, health providers, family groups, community based organizations, advocacy groups and other MCH stakeholders. This will be done in conjunction with the Office for Genetics and Children with Special Health Care Needs. Finally, enhancing the Center's data and epidemiological capacity is an ongoing priority.

The Office for Genetics and Children with Special Health Care Needs will be dealing with a number of significant issues in the next few years. In general, the structural State budget deficit and resulting cuts to the Departmental budget and an increasingly conservative political climate create challenges for all public health programs, including MCH programs. More specifically, on the genetics front, these include the fragmentation of the newborn bloodspot screening program by the licensure of a private laboratory in competition with the State Public Health Laboratory, obtaining the legislative changes needed to bring the birth defects program up to the new CDC standards, and the closure of the AFP/Quadruple Marker Screening laboratory in the State Public Health Laboratory.

*//2009// See below for OGCSHCN issues) //2009//*

On the CSHCN front, the issues include the creation of a cabinet level Office of Disabilities, major changes to the REM (Rare and Expensive Disease Case Management) Program in Medicaid, the transition of the CMS (Children's Medical Services) program to electronic bill paying, the elimination of Medicaid coverage for legal immigrants, new legislation mandating a pilot autism screening project and overcoming barriers to collaborating with partners outside State government such as professional organizations, like the Maryland Chapter of the AAP.

*//2007/ An additional priority focuses on implementation of the medical home state plan developed over the past year. This plan incorporates strategies that target CYSHCN and their families, pediatric health care providers/practices, and state and local agencies to optimize the care of Maryland CYSHCN through medical home partnerships. //2007//*

***//2009/ The development of a Maryland Community of Care Consortium for CYSHCN that will engage diverse partners in shared planning, implementation, and evaluation of strategies to achieve six core components of a system of services for CYSHCN built on evidence-based practices is a priority for the coming year. The Consortium will be kicked off with a Community of Care for CYSHCN Summit to be held in November 2008. //2009//***

In 2000, NeoGen Screening, a commercial newborn screening laboratory, appealed the denial of a license to conduct newborn screening in Maryland. NeoGen had previously been granted a license as a molecular diagnostic laboratory, but had been denied a license to do newborn screening. In May of 2002 NeoGen Screening received a license to perform newborn screening tests as part of a settlement agreement. Under the terms of the settlement, Neo Gen was to report abnormal test results to the Newborn Screening Follow-Up unit in the OGCSHCN who would continue to provide follow up services. NeoGen was also to provide data on all Maryland babies screened to the Follow-Up unit and to provide data on the babies it screened for required reports, such as the MCH Block Grant and the National Newborn Screening and Genetics Resource Center's annual report. NeoGen Screening was then acquired by Pediatrix. The new leadership was much less experienced with newborn screening and the mechanics of comprehensive state newborn screening programs.

Despite the best efforts of all concerned, the difficulties of running a comprehensive State newborn screening program with two laboratories have proven much greater than anticipated. Meshing the 2 data systems has been much more difficult than expected. This has been further complicated by differing interpretations of HIPAA compliance requirements and the expectations of all parties. Consequently, Maryland's newborn screening data may be incomplete. Maryland continues to address these issues and anticipates that as the "learning curve" evolves a

significant number of these concerns will be resolved. This affects both blood spot screening and hearing screening because Maryland collects the results of hearing screening performed in the hospital before discharge on the newborn blood spot screening lab slip. This issue is will increase in significance as more Maryland hospitals use Pediatrix.

In CY 2004, Pediatrix screened about 5% of the babies. By the beginning of 2005, Pediatrix had contracts in place to cover approximately one third of babies born in Maryland. (Maryland has a routine 2 specimen system and some babies, for instance premies or babies with mildly abnormal results, may have more specimens.) Work on database issues and negotiations on reporting are ongoing.

//2007/ The above issues continue to evolve. Meshing the databases has proven beyond our capabilities and the program maintains 2 separate databases, only importing abnormal results from Pediatrix into the follow up database to form a single abnormal follow up database. Maryland implemented newborn screening for cystic fibrosis in 2006. Pediatrix has always used the IRT/DNA method but the Maryland Advisory Council decided that the State lab should use the IRT/IRT method. The settlement agreement under which Pediatrix is licensed requires them to use the method selected by the Advisory Council for Maryland babies. This has resulted in Pediatrix reporting only IRT results to the OGCSHCN's follow up unit and reporting the DNA results separately to the hospital or physician. This confuses physicians and makes it difficult to intelligently conduct follow up. Pediatrix has medico legal concerns about not doing DNA testing on a subset of the babies it screens. Clearly this new data exchange impasse must be resolved.  
//2007//

//2008/ Operating a Statewide newborn screening follow up program with 2 laboratories remains a challenge but progress is being made. The problem with cystic fibrosis screening has been largely resolved. Pediatrix now reports complete abnormal results, including the DNA analysis, to the OGCSHCN for follow up. This means that the follow up protocol differs slightly depending on which lab is used but this is preferable to confusing primary care providers. The newborn screening follow up program is also facing a manpower crisis. The veteran nurse in follow up program retired due to ill health. This required the OGCSHCN director, an ABMG certified medical geneticist, to step in to do the follow up until additional personnel could be recruited. Dr Ngozi Nwokoro was reassigned from the adult sickle cell disease project and a genetic counselor, Lucy Talbot, was recruited through the University of Maryland. However, this is a temporary arrangement and the genetic counselor is relocating this fall, again leaving the program with insufficient manpower. A combination of factors requires the reorganization of the newborn screening follow up program. These factors include the rapid expansion of the program and the follow up workload, additional expansions expected in the near future (lysosomal storage disorders, SCID, ALD, fragile X, etc), the need for a new follow up database, the difficulty of recruiting and retaining qualified personnel willing to take night and weekend call, the promotion of the labor intensive PEAS quality assurance protocol and changing culture of the Family Health Administration away from clinical programs. A number of possibilities are under consideration but the reorganization will most likely consolidate the lab and follow up components under the auspices of the Laboratories Administration and procure personnel and expert back up through an MOU with the University of Maryland.//2008//

***//2009//Obstacles to operating the Newborn Screening (NBS) Program with two labs proved insurmountable. Legislation, HB 216, was introduced, hotly contested but eventually passed to restrict first tier newborn screening (NBS) to the State Public Health lab. HB 219 takes effect January 1, 2009. Restoration of a single laboratory should result in better data and better follow up since all abnormalities will be reported. The NBS fee will be raised to cover a new data system, replacement of aging equipment and follow up costs. The NBS program will be reorganized with the follow up unit moving to the Laboratories Administration, which will assume administrative responsibility for the entire program. A report on the policy of informed consent for newborn screening is being prepared in response to a group wishing to change that policy. A new follow up nurse,***

***Johnna Watson, and a new genetic counselor, Carolyn Dinsmore, were recruited. All research (usefulness of the second screen) and test development (SCID, ALD) continues and a project to estimate the birth prevalence of a variant gene for osteogenesis imperfecta, that seems to occur only in African Americans, was initiated with Dr Joan Marini from the NIH. //2009//***

The Maryland Birth Defects Reporting and Information System (BDRIS) currently receives a grade of C from the Trust for America's Health. While praising the timeliness of Maryland data, Maryland's use of the data it collects, and the information and referral services it provides, the Maryland system is marked down because it does not collect data on all birth defects and because it does not have clear-cut authority to access medical records. These deficiencies will have to be corrected for the Maryland system to meet the newly published CDC standards.

A bill was introduced in the 2005 legislative session to correct these deficiencies. It was amended in the House of Delegates because the parents of children with facial clefts felt that it was discriminatory to allow hospitals to release information about babies with birth defects to the Department without the informed consent of their parents while asking for informed consent to release information about possible control babies to the Department, so that the program could invite possible controls to participate in case/ control studies. (Informed consent is always obtained before including babies with or without birth defects in studies that are purely research and not investigations necessary to protect the public health.) The amended bill allowed the hospitals to provide initial information, contact information only on control babies, without informed consent. This was felt by the parents to treat cases and controls the same way. The bill passed the House but failed in the Senate because some Senators thought it was unacceptable for even contact information on infants without birth defects to be released to the Department without explicit informed consent, even though the information would only be used to contact the families to get informed consent. This impasse will have resolved.

//2007/ The bill is being rewritten and will be re-introduced in 2007, probably with independent sponsorship. //2007//

//2008/ The birth defects bill was again not included in the Departmental legislative package because of higher priority issues and permission to seek independent sponsorship was not granted. The bill is being rewritten to meet the requirements of the O'Malley administration and will again be considered for inclusion in the Departmental legislative package for 2008. The birth defects program lost its veteran data manager because of ill health and is being operated solely by the birth defects nurse. A new database for the program has been under construction. Fortunately, the new system can match birth defect reports with vital records and produce some of the reports previously produced by the data manager. A freeze exemption will be sought to fill the data manager position. The program has enjoyed a closer relationship to the environmental health section of the Community Health Administration with the arrival of Dr Clifford Mitchell to head that program. Funding from the Environmental Public Health Tracking grant has made database enhancements possible and will enable the program to post statistics as part of that effort. //2008//

***//2009// HB 438/SB 828 were passed, providing the birth defects program with clear cut authority to review medical records without individual informed consent for data gathering, validation and QA, and for service provision. The bills also provide authority for the collection of data on all significant birth defects rather than just the 12 WHO "sentinel defects". An Advisory Committee will update data collection forms and educational materials. The data managers position is being reclassified and the work is being done by and intern, Barbara Do from Emory University. The relationship with the Environmental Public Health Tracking continues and the database is live and being modified to accept the new data allowed by the law. //2009//***

In the early 1980s the State Public Health Laboratory began to provide maternal serum AFP testing. When AFP testing began to be available in the private sector, the State decided not to establish AFP testing as a State program for all pregnant women. The State left the provision of this test to the private sector and only provided it as a service to low income women who could otherwise not access the test. The number of women utilizing this service declined dramatically after 1997 when medical assistance patients were transitioned to MCOs. The State AFP/Quadruple Marker Laboratory was closed in February 2004 since only approximately 3,000 women/yr were tested. A short term contract to serve this patient population was established with the genetics laboratory at the University of Maryland. OGCSHCN continues to assess ways to continue funding this genetic test now that the interim funds have been depleted. None of these low income women are eligible for any public insurance program.

/2007/ The OGCSHCN continues to support this contract on a yearly basis as long as funds are available but a long term solution has not yet been found. //2007//

/2008/ Funding was again found to keep this service operating but a long term solution is still not in sight.//2008//

***//2009//AFP/Quadruple Marker screening continues to be available through an arrangement with the AFP Lab at the University of Maryland which is funded by a small grant from the OGCSHCN. //2009//***

The Department of Disability was elevated to cabinet level in 2004. The Department of Disability was charged with writing a Statewide disability plan. All State programs providing services to persons with disabilities were required to report their activities to the new Department of Disability every year and to configure their programs to achieve the plans goals. The plan has just been released. The Department of Disability is granted very broad authority to implement the plan. It is not yet clear what the impact on the programs of the OGCSHCN will be. The programs of the OGCSHCN serve some children with disabilities and some who are not considered disabled.

/2008/ The Department of Disabilities has incorporated items related to medical home and health insurance for children and youth with disabilities into its state plan. Although the OGCSHCN has been designated as lead on the medical home efforts, it is not clear what will be accomplished beyond current activities without the development of new state/local agency collaborative partnerships and the input of additional resources targeted towards medical home improvement. //2008//

The future of the REM program has been a prominent issue this year and will continue to be a highly visible issue in the next year. The REM (Rare and Expensive Disease Case Management) Program was created in 1997 at the time that Medicaid transitioned its patients into managed care (HealthChoice). Only a few special populations remained in fee for service Medicaid. Among these were a small number of patients with rare, expensive, complex disorders who were judged very likely to do poorly in the managed care setting. A major concern was that the MCOs had not yet developed adequate networks of specialty providers, especially pediatric specialty providers. The REM patients receive case management and remain in fee for service Medicaid. They are allowed to assemble their own group of specialists, free of network constraints, and to have access to services not ordinarily covered by Medicaid if these are required for their care.

The REM population contained many CSHCN; 2850 (85%) of the approximately 3,300 patients enrolled in the program were CSHCN. Since diagnosis was the major criterion for eligibility for REM, there was a broad spectrum of severity for each diagnosis. Fewer than 6% of the REM patients accounted for over 40% of total REM expenditures. Approximately 20% of the highest cost patients are in their terminal year of life. Due to the total cost of the REM case management and its impact on the total Medicaid budget, in 2004, case management was eliminated for approximately two thirds of REM patients and retained only for the most severely affected third.

Various committee reports found that, with more developed specialty provider networks and improved case management, MCOs were now successfully handling many patients as complex as REM patients whose diagnoses were too common for eligibility in REM. The elimination of REM and transition of REM patients into HealthChoice MCOs was proposed as an additional cost containment measure. However, budget language in the FY 2006 budget retains the program for another year while requiring a number of reports including a study of the utilization of durable medical equipment (DME), the development of cost containment strategies and the consideration of alternatives to the program.

/2007/ As a result of the studies of DME utilization, the REM program now requires the case managers to use a standard DME request assessment tool in deciding whether to request specific DME. In addition, REM case managers are provided patient specific cost and utilization data on a quarterly basis to assist them in managing their patients. //2007//

Changes to REM or the elimination of REM may have a substantial impact on the CSHCN program. The CMS program historically provided "underinsured" low income CSHCN with specialty care services that are not covered by Medicaid or private insurers. Many benefit packages in the private sector do not cover care or services needed by CSHCN with complex problems. In 2004, 56% of the calls received by Parent's Place of Maryland (funded by OGCSHCN) are from families with private insurance whose insurance does not cover items needed by their children.

To comply with HIPAA, the CMS program is working on a system to pay bills electronically and proving to be more difficult than anticipated. /2007/ The difficulties with the electronic bill paying system proved insurmountable and the program returned to manual bill paying for the moment. Other alternatives are being explored. //2007//

The FY 2006 State budget eliminates Medicaid eligibility for approximately 3,000 children who are legal immigrants but who have not lived in Maryland for a minimum of 5 years. It is anticipated that some of the children with special health care needs in that group will seek fee for service coverage for their specialty care from the CMS program. This could potentially increase the caseload in the CMS program by 450 children, which is approximately 3 times the number of patients currently in the program. /2007/ The Governor has included an Immigrant Health Initiative in his budget to assist families losing Medicaid in accessing needed services through other means. The funding will go primarily to local health departments, but the CMS program budget will also be increased to absorb the specialty care needs of the CSHCN in the affected population. //2007//

/2008/ Fortunately, the past year saw reinstatement of Medicaid eligibility to many Maryland legal permanent resident children who previously lost coverage. With this reinstatement, however, additional monies that had been put in the public health budget to shore up the public health infrastructure to assist uninsured Marylanders were lost, including funds to pay for additional services through the CMS Program. While CMS has seen a leveling off of its enrollment, overall enrollment in the program continues to exceed previous years.//2008//

Autism will also be a prominent issue in the near future. A bill to establish a pilot program of screening for the early identification of autism was passed in the 2005 legislative session. The project is based in the Maryland Department of Education but the Department of Health and Mental Hygiene is collaborating and the Associate Director of the OGCSHCN, who is a developmental pediatrician, serves on the advisory board for the project. In addition, the Director of the OGCSHCN serves on the Advisory board of the Center for Autism and Developmental Disabilities Epidemiology based at the Johns Hopkins School of Public Health. /2008/ The state's focus has expanded to general developmental screening with Maryland's selection to participate in the ABCD Screening Academy. The Maryland Medicaid program, the OGCSHCN, and the Maryland AAP are leading this effort aimed at policy and practice changes needed to support

improvements in developmental screening.//2008//

OGCSHCN staff will work to overcome the barriers to collaborating with partners outside State government on an increasing number of grants that require such collaboration. Both the Champions for Progress Grant and the Medical Home Work Group require collaboration with the Maryland Chapter of the American Academy of Pediatrics. The State procurement system makes it almost impossible for a State agency to provide such a professional organization with the funding for its part of the grant. In addition, the Maryland AAP Chapter lacks the staff and organization to do its part. This is an increasing concern since many new initiatives require such collaboration.

## **B. Agency Capacity**

### **B. Agency Capacity**

Both the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHN), hereafter referred to as the MCH Program, share responsibility for MCH Block Grant development and implementation. The mission of the Maryland's MCH Program is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities, and strengthening the MCH infrastructure.

The MCH Program is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statutes relevant to Title V program authority include the following:

Child Fatality Review Teams (HEALTH GENERAL, Article 5, SS701) -- Establishes multi-disciplinary, multi-agency State and local child fatality review teams for the purpose of preventing child deaths. Administrative support is to be provided by the CMCH.

Hereditary and Congenital Disorders Program (HEALTH GENERAL, Article 13, SS101) -- Establishes an Advisory Council and programs to address hereditary and congenital disorders. Administratively placed within the OGCSHCN.

General Regulations For Hereditary Diseases (COMAR 10.52.01) (several programs related to genetic disorders are mandated in regulation rather than statute)- Establishes quality assurance standards for hereditary and congenital disorders services procured by the State. These regulations are administered by the OGCSHCN.

Program for Hearing Impaired Infants (HEALTH GENERAL, Article 13, SS601) -- Establishes a program for universal hearing screening of newborns and early identification and follow-up of infants at risk for hearing impairment. This Program is administratively placed in OGCSHCN.

Sickle Cell Anemia (HEALTH GENERAL, Article 18, SS 501) -- Establishes a program for screening newborns for sickle cell anemia, monitoring each affected infant's health and providing prenatal education regarding sickle cell anemia. Informed consent is required for screening. This program is part of the bloodspot newborn screening and follow up program administered by the OGCSHCN.

Screening for Treatable Disorders in the Newborn Child (COMAR 10.52.12)-- Establishes a voluntary program to offer newborn screening for treatable metabolic disorders. Informed consent

is required for screening. This program is administered by the OGCSHCN. /2007/ These regulations are being updated to encompass the new technology and expanded panel of disorders. //2007// **//2009// New legislation (HB 216, 2008) was passed restoring a single newborn screening (NBS) lab. This is the first time that NBS has been put in statute. New regulations are being drafted.//**

**Screening for Sickle Cell Disease, Thalassemia and Related Conditions (COMAR 10.52.13)- Establishes a voluntary program for population based carrier screening for these conditions. This program does not include newborns or those thought to be at risk on clinical grounds. This program is administered by the OGCSHCN.**

**Screening for Neural Tube Defects in the Fetus (COMAR 10.52.14)-Establishes a program to offer biochemical maternal serum screening to identify mothers at increased risk for carrying a fetus with a neural tube defect or a chromosomal anomaly. This program is administered by the OGCSHCN.**

**//2008/ All of the regulations of the OGCSHCN pertaining to genetics have been revised. The revision of COMAR 10.52.12., the newborn screening follow up regulations, was carried out in conjunction with the regulations for newborn screening laboratories, COMAR 10.10.13. The entire package of revised regulation is currently under study by the Chief Council for the Department of Health and Mental Hygiene in the Office of the Assistant Attorney General. //2008// //2009// Because of new legislation (HB 216, 2008) putting the NBS program in statute for the first time, new regulations are being drafted.//**

Maryland Asthma Control Program (HEALTH GENERAL, Article 13, SS701) -- Establishes the Maryland Asthma Control Program within DHMH. The Program is administratively housed within CMCH.

Maternal Mortality Review Program (HEALTH GENERAL, Article 13, SS1201)-Establishes a program to review maternal deaths and develop strategies to prevent deaths. Support is provided by the CMCH.

Children's Environmental Health Advisory Council (HEALTH GENERAL, Article 13, SS501) -- Creates a Council which is charged to identify environmental hazards that may affect children's health and to recommend solutions. CMCH chairs and staffs the Council.

Lead Poisoning Screening Program (HEALTH GENERAL, Article 18, SS106) -- Establishes a Lead Screening Program to assure appropriate screening of children. This Program is administratively placed within CMCH.

Disease Prevention (HEALTH GENERAL, Article 18, SS107) -- Directs the Secretary to devise and institute means to prevent and control infant mortality, diseases of pregnancy, diseases of childbirth, diseases of infancy, and diseases of early childhood as well as to promote the welfare and hygiene of maternity and infancy. This mandate applies to programs administered within CMCH and OGCSHCN.

Sentinel Birth Defects (HEALTH GENERAL, Article 18, SS206) -- Requires hospitals to report sentinel birth defects to the Secretary. Also requires the Secretary to monitor birth defects trends. OGCSHCN is administratively responsible for the program. The program unsuccessfully sought to change this statute in the 2005 legislative session. Legislative change was sought to authorize the collection of data on all significant birth defects rather than just a few "sentinel" defects, bringing the program in line with CDC standards. The proposed change would also have clarified and strengthened the language allowing the program to access medical information related to the birth defect from medical records, again bringing the program up to CDC standard. Passed in the House of Delegates, the bill failed in the Senate because of a disagreement regarding the need

for informed consent to access the names and addresses of possible controls for the purpose of informing them of a study and inviting their participation. Actual participation is always with informed consent and under IRB supervision. An amended bill will be proposed in the 2006 session.

/2007/ The bill was not included in the Departmental legislative package for 2006 but is being rewritten and will be introduced in 2007, probably by an independent sponsor. //2007//

/2008/ The birth defects bill was again not included in the Departmental legislative package because of higher priority issues and permission to seek independent sponsorship was not granted. The bill is being rewritten to meet the requirements of the O'Malley administration and will again be considered for inclusion in the Departmental legislative package for 2008.//2008//

**//2009// New legislation (HB438/SB 428) modifying this statute was passed and gives expanded authority to access medical records and to collect data on all significant birth defects.//2009//**

School Health (EDUCATION, Article 7, SS401) -- Requires the Department of Education and the Department of Health and Mental Hygiene to jointly (1) develop public standards and guidelines for school health programs; and (2) offer assistance to the county boards and county health departments in their implementation. School health activities are housed within CMCH.

Program for Crippled Children (HEALTH GENERAL, Article 15, 125) - Establishes a program to identify and to provide medical and other services to "children who are crippled or who have conditions related to crippling". Administratively placed within the OGCSHCN.

Fetal and Infant Mortality Review (HEALTH GENERAL, Section 18-107) This activity is administratively placed within CMCH.

/2008/A Department bill to place a State fetal and infant mortality review team in statute was withdrawn by the sponsor in 2007. CMCH is redrafting a bill for resubmission in 2008.//2008//

**/2009/ In 2008, the General Assembly passed House Bill 535, mandating that the Department of Health and Mental Hygiene establish a Morbidity, Mortality and Quality Review Team to conduct case reviews and enact interventions to prevent and control mortality and morbidity associated with pregnancy, childbirth, infancy and early childhood (HEALTH GENERAL, Chapter 664). This law establishes a State Fetal and Infant Mortality Review Committee in statute, standardizes the review and information gathering processes and ensures the confidentiality of data collected. //2009//**

Lead Poisoning Screening Program - Implementation (COMAR 10.11.04) CMCH is administratively responsible for this Program.

Family Planning (Family Law Article, Section 2-405) The Family Planning Program is required to distribute a Family Planning brochure to all marriage license applicants.

CMCH is responsible for developing Perinatal Systems Standards which are incorporated in the following regulations:

COMAR 10.24.12 (State Health Plan: Acute Hospital Inpatient Obstetric Services)

COMAR 10.24.18 (State Health Plan: Specialized Health Care Services -- Neonatal Intensive Care Services)

COMAR 30.08.01 (MIEMSS -- Designation of Trauma and Specialty Centers)

Legislation passed during 2004 requires the Secretary of Department of Health and Mental Hygiene to establish and promote a statewide campaign on fetal alcohol syndrome and other effects of prenatal alcohol exposure. This activity is placed administratively in the Center for Maternal and Child Health.

MCH programs and services in Maryland are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. Both CMCH and OGCSHCN work collaboratively to ensure that Title V funds are administered efficiently and according to best practice standards in public health.

The mission of the Center for Maternal and Child Health is to improve the health and well-being of all women, newborns, children and adolescents in Maryland. Ms. Bonnie S. Birkel serves as the Center's director. As the attached organization chart shows, the Center is comprised of three major divisions: Operations, Policy Development and Program Management. Program Management includes Family Planning and Reproductive Health; MCH Systems Improvement and Community Partnerships. The Service System Development Initiative (SSDI), Asthma, and Early Childhood Systems Development, and Title X Family Planning grants are administered by CMCH. Administrative changes at the federal level resulted in the transfer of administrative responsibility for the Abstinence Education Program from DHMH to the Department of Human Resources (DHR). However, DHMH petitioned the Governor and was able to maintain fiscal and administrative control for the Program.

The goal of the Family Planning and Reproductive Health Program is to improve the health of women of reproductive age by assuring that comprehensive, quality family planning and reproductive health care services are available and accessible to citizens in-need. The target population includes clients in need of subsidized family planning services, with special attention to those who are uninsured and with incomes under 250% of federal poverty guidelines. The Program is consistent with federal and state mandates to lower the incidence of unintended pregnancy and promote the health of women of reproductive age (Health General, Article 18, Section 107 of the Annotated Code of Maryland, and Title X of the U.S. Public Health Services Act of 1970). Program efforts are designed to (1) assure that Maryland communities offer family planning and reproductive health services to clients in need; and (2) develop a coordinated approach for assuring quality patient care services, educational activities, and evaluation efforts in order to improve reproductive health outcomes.

The Family Planning Program administers the following services: Family Planning Clinical Services, Reproductive Health Services that include colposcopy, cancer screening program and sexually transmitted disease treatment, the Healthy Teens and Young Adults program and the Adolescent Pregnancy Prevention Program. Program activities include the following:

1. Assuring reproductive health care to over 70,000 clients each year through a statewide network of over 80 ambulatory sites located in local health departments, outpatient clinics, community health centers, Planned Parenthood affiliates, and private provider offices;
2. Providing an array of preventive health care services including contraceptive care, colposcopy services, reproductive health education and counseling, sexually transmitted disease services, HIV/AIDS prevention services, breast and cervical cancer screening, cardiovascular risk screening, and referrals for indicated health and social services;
3. Developing community-based outreach strategies for reaching and serving young people, both males and females, who are at risk for unintended pregnancies;
4. Organizing workgroups of health professionals and community members to set standards for clinical care; and
5. Assuring compliance with Title X Federal Family Planning regulations and guidelines.

Maternal and perinatal health programs seek to prevent maternal and infant deaths and other adverse perinatal outcomes by promoting preconception health, assuring early entry into prenatal care, and improving perinatal care. In collaboration with local health departments, hospitals, private providers, professional organizations and community groups, these programs work to assure and improve the quality of services for the 70,000+ infants born each year in Maryland. Programs are consistent with federal and state mandates to reduce infant mortality and promote the health of women and children (Health General, Article 18, Section 107 of the Annotated Code

of Maryland, and Title V of the U. S. Social Security Act of 1935). Activities include:

1. Assuring access to maternal health services, including medical care, risk assessment, prenatal education, case management, smoking cessation counseling, genetic screening, high-risk referral, home visiting, assistance in obtaining hospital-based services, and referral for family planning, and preconception health care;
2. Support of a Toll Free Maternal and Child Health Hotline (1-800-456-8900) that assists pregnant women seeking prenatal care;
3. Funding of regional perinatal improvement activities (Crenshaw Perinatal Health Initiative);
4. Perinatal systems building in each jurisdiction including Fetal and Infant Mortality Review, provider education, and public awareness efforts;
5. Development of perinatal standards and support for Perinatal Center Review and Designation;
6. Administration of the Pregnancy Risk Assessment Monitoring System (PRAMS), a statewide survey that identifies and monitors selected maternal behaviors;
7. Promotion of preconception health including the use of folic acid preconceptionally (Folic Acid Council);
8. Breastfeeding Promotion in cooperation with the Maryland Breastfeeding Promotion Task Force *//2009/ Evolved into the Maryland Breastfeeding Coalition in FY 2008 //2009//*;
9. Maternal Mortality Review in cooperation with the Vital Statistics Administration and the State's Medical Society;
10. Funding for Sudden Infant Death Syndrome (SIDS) related educational and family support activities;
11. Supporting state activities to identify and address Fetal Alcohol Spectrum Disorders (FASD);
12. Supporting state activities to address postpartum depression; and
13. Sponsoring maternal and child health meetings and conferences.

Child and adolescent health programs seek to promote and protect the health of Maryland's 1.5 million children and adolescents, ages 0-21, by assuring that comprehensive, quality preventive and primary services are available and accessible. This is accomplished through a comprehensive, integrated system of care that provides: (1) direct and enabling services to underinsured and uninsured children and (2) population based services to Maryland's children, adolescents and young adults who would be at risk if preventive public health measures and health messages were not available. Leadership, consultation, training and technical assistance are provided in several program areas including school and adolescent health, care coordination and home visiting, environmental health and child fatality review. The Program collaborates with numerous DHMH programs and other State agencies in the development of policies and programs. Activities include:

1. Assuring access to child health services including medical care, risk assessment for families and adolescents, case management and home visiting, screening, referrals and assistance obtaining a medical home;
2. Facilitating the development of regional/community child and adolescent health plans;
3. Providing medical consultation and technical assistance to school health programs;
4. Teen pregnancy prevention;
5. Administering the Maryland Abstinence Education and Coordination Program;
6. Promoting early childhood health initiatives including administering the Childhood Lead Screening Program and evaluating Maryland's Targeting Plan for Areas At Risk for Childhood Lead Poisoning to assure appropriate screening and testing of all children at risk for lead poisoning;
7. Implementing the Child Fatality Review (CFR) mandate including supporting the State Child Fatality Review Team;
8. Supporting the Children's Environmental Health Protection Advisory Council;
9. Administering the Maryland Asthma Control Program including implementation of both a statewide asthma plan and an asthma surveillance system;
10. Planning to prevent childhood overweight and obesity;
11. Supporting State activities to reduce child abuse and neglect; and

12. Working with the Medical Assistance Program to increase enrollment in MCHP and other Medical Assistance Programs.

The goal of the Women's Health Program is to assess and address health issues that commonly, uniquely, or disproportionately affect women throughout their life span. This Program partners with other program areas to facilitate access to comprehensive preventive and primary care services that incorporate the unique needs of women. The Women's Health Program was established by issuance of an Executive Order in 2001. Program activities include:

1. Administration of the Women Enjoying Life Longer (WELL) Project, a former demonstration project funded under the MCHB grant program, "Integrated Comprehensive Women's Health Services in State MCH Programs." The goal is to integrate and coordinate preventive health services to promote wellness among women enrolled in family planning programs. CMCH has made the commitment to sustain funding for the WELL Project

2. Publication of materials to promote and improve the health of women. Current publications include a booklet on postpartum depression

([www.fha.state.md.us/womenshealth/pdf/postpartum\\_booklet.pdf](http://www.fha.state.md.us/womenshealth/pdf/postpartum_booklet.pdf)) and a report on the health of Maryland women ([www.fha.state.md.us/mch/pdf/WomensHealth-Publication.pdf](http://www.fha.state.md.us/mch/pdf/WomensHealth-Publication.pdf).)

The Division of Community Partnerships is responsible for developing initiatives and strengthening community partnerships with community organizations, advocacy groups, universities and professional groups to improve maternal and child health. This Unit shares responsibility with other programs where community involvement, outreach and partnering are crucial to program success. Examples include Abstinence Education, Pregnancy Risk Assessment Monitoring System (PRAMS), and teen pregnancy prevention.

***//2009/ This Division was reorganized as the Division of Federal State MCH Partnerships in FY 2008. This Unit is responsible for managing several federal programs including asthma and abstinence as well as Title V coordination and planning. //2009//***

The mission of the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) is: (1) to reduce death, illness and disability from genetic disorders, birth defects, chronic diseases and injuries and to improve the quality of life for these individuals, and (2) to protect and promote the health of Maryland's children with special health care needs by assuring a family-centered, community-based, comprehensive, coordinated and culturally appropriate system of specialty health care. As the organization chart shows, the OGCSHCN is comprised of six divisions: Newborn Blood Spot Screening and Follow-Up (including sickle cell disease), Newborn Hearing Screening Follow- Up, Birth Defects, Metabolic Disease Nutrition, Specialty Care and Regional Resource Development and Program Support.

The Division of Newborn Screening and Follow-Up screens babies for 32 disorders. The disorders are: 3 amino acid disorders (PKU, homocystinuria, and tyrosinemia), 3 urea cycle disorders, 13 disorders of organic acid metabolism (including MSUD and Biotinidase Deficiency), 9 disorders of fatty acid metabolism, Galactosemia, Congenital Adrenal Hyperplasia, Hypothyroidism, and Sickle Cell Disease.

//2007/ The capacity of the newborn screening program increased over the last year. The State lab hired an ABMG certified biochemical geneticist from the University of Maryland as a part time consultant. The state lab continued to refine its MS/MS techniques and cut offs for various analytes. New standards were added allowing the quantitation of additional analytes and the use of ratios to identify abnormal profiles. The additional standards also allowed the addition of several disorders such as carnitine uptake disorder. This brought Maryland to 34 disorders. The Advisory Council worked on the details of adding cystic fibrosis to the screening panel and chose the IRT/IRT method for Maryland. With the addition of CF to the screening panel, Maryland screens for 35 disorders including all those recommended by the AGMG and the AAP. //2007//

/2008/ The newborn screening program added malonic acidemia to the panel in 2007 bringing the total number of disorders to 36. Maryland screens for all the disorders recommended by the AGMG and the AAP and the March of Dimes. Maryland screens for all 29 primary target disorders and can pick up the 25 secondary target conditions. It should be remembered that many of these conditions are part of the differential diagnosis of an abnormality in the marker used for a core condition and some would be suspected because of an unusual profile even if a standard for the primary marker is not run. Maryland follows up all significantly abnormal profiles whether or not the profile is associated with a known disorder. //2008//

***/2009/ the NBS program screens for all the disorders recommended by the ACMG, AAP and March of Dimes including the secondary targets. New legislation (HB216) restores a single newborn screening lab and reorganizes the program. A fee increase will make the program including follow up fiscally self sustaining.//2009//***

All babies born in Maryland, (70,000+ per year), are eligible for service. This Division also includes Carrier Screening for sickle cell disease, Thalassemia and Tay-Sachs Disease as well as AFP/Multiple Marker Screening to detect neural tube defects.//2009//

***/2007/ The State lab closed their AFP/Multiple Marker lab because of low volume. However, the OGCSHCN continues to support AFP/Multiple Marker Screening for low income women unable to access the service any other way by funding the service at the University of Maryland. //2007//***

***/2008/ Funding was again found to keep this service operating but a long term solution is still not in sight.//2008//***

***/2009/AFP/Quadruple Marker screening continues to be available through an arrangement with the AFP Lab at the University of Maryland which is funded by a small grant from the OGCSHCN. //2009//***

The Division of Newborn Hearing Screening Follow Up is supported by a grant from MCHB. This Division has been severely short staffed for the last several years. The Division lost its Chief in 2003 and was unable to replace him because of a hiring freeze. The junior audiologist left in 2004. The Division was folded into the bloodspot screening program to assure continued service to the babies of Maryland. However, an exception to the hiring freeze was obtained, 2 audiologists are being recruited and the Division should be able to operate independently again.

/2007/ Two audiologist were hired and the program now has a director and is operating independantly again. Unfortunately, the junior audiologist soon left for a better position. The Department's payscale is simply not competitive for audiologists. In addition one of the follow up specialist positions has turned over twice for the same reason. These positions are contractual and do not have benefits. We are seeking to convert them to regular State positions in hopes of retaining staff with a better package. //2007//

/2008/ The infant hearing program has made great strides in the last year. Permission was received to make the positions for the second audiologist and one of the follow up specialists federally funded permanent positions with benefits. Although these positions will end when the infant hearing screening grant ends, unless other funding can be found for them, the benefits are a major asset in terms of employee retention. At the moment, the infant hearing screening program is fully staffed for the first time in its history. Procedures have been standardized and procedure manuals written, hospital site visits are being made, NICUs were targeted to improve reporting of screenings on NICU babies, a programmer was hired to improve the current data system and a new web-based system is in procurement. The improvements in the data system have made the de-duplication of records more efficient. As an artifact of this, the percentage of infants screened appears to have remained about the same or even declined, although we suspect the percentage screened has actually improved. //2008//

***/2009/ the infant hearing screening program is fully staffed for the first time, although one position remains contractual. The program is still heavily dependant of the HRSA grant which covers the salaries of 2 staff persons. A new database (OZ) with online data entry from the hospitals was procured and is in the process of bringing the last half of the hospitals on board. //2009//***

The Division of Metabolic Disease Nutrition follows patients with genetic metabolic disorders like PKU or MSUD and provides case management, dietary therapy, support groups and a summer camp. /2008/ The Division of Metabolic Disease Nutrition now also serves children with organic acidemias requiring dietary therapy.//2008//

The Birth Defects Division includes the Birth Defects Reporting and Information System, which collects data on the number of babies born with any of 12 common birth defects and provides information on the defects and services available. The Chief of the Birth Defects Reporting and Information System in the OGCSHCN is also the mother of a child with a birth defect and adds a mother's perspective to that program. The Department will return to the Legislature in 2006 to seek legislative change to broaden the scope of the program's data collection and to strengthen and clarify its authority to access information from medical records.

/2007/ The bill was not selected to be in the Department legislative package for 2006 but it is being rewritten and will be introduced in 2007 probably by an independant sponsor. //2007//

/2008/ The birth defects bill was again not included in the Departmental legislative package because of higher priority issues and permission to seek independent sponsorship was not granted. The bill is being rewritten to meet the requirements of the O'Malley administration and will again be considered for inclusion in the Departmental legislative package for 2008.//2008//

/ 2009/ New legislation (HB438/SB 428) modifying this statute was passed and gives expanded authority to access medical records and to collect data on all significant birth defcts.//2009//

***The Division of Specialty Care includes the Children's Medical Services Program (CMS), the Regional Resource Development Program, the Medical Day Care Program, and the Genetic Services Program. The Children's Medical Services Program (CMS) had historically served as the payer of specialty services for a large population of children with special health care needs in the state, serving over 12,000 children at its peak. Over the last 8 years, the need and demand for this program has been quite variable and the program has undergone major changes. The expansion of Medicaid in the 1990s lessened the need for the program as most CMS patients became eligible for other programs. The program was redesigned and funds redirected to care coordination, other enabling services, systems development and the dissemination of information about the services available. In the last few years, the program served a small number of children (135 in FY 2004), most of whom were undocumented. However, the FY 2006 state budget eliminates Medicaid eligibility for approximately 3,000 children who are legal immigrants but who have not lived in Maryland for a minimum of 5 years. It is anticipated that the children with special health care needs in that group will seek fee for service coverage for their specialty care from the CMS program. This could potentially increase the caseload in the CMS program by 450 children or roughly a factor of four.***

***/2007/ CMS enrollment is currently up to 209 patients, with 18 applications pending and applications still coming in. In FY 2006 alone 137 new applications were received. A Governor's Immigrant Health Initiative will increase the CMS program's budget in view of the increased caseload. //2007//***

***/2008/ While CMS has seen a leveling off of its enrollment with reinstatement of Medicaid eligibility for many legal immigrant children, overall enrollment in the program continues to exceed previous years. //2008//***

***The Regional Resource component of OGCSHN funds 21 of the state's 24 local health departments in FY 2005 for a variety of services including the provision of specialty clinics for uninsured and underinsured children, care coordination, respite care, assessment of family and community needs and service capacity building. The scarcity of specialty providers willing to accept Medicaid rates in the outlying areas of the state and the failure of local hospital specialty clinics to break even, lead the Maryland Association of Local Health Officers to request a re-expansion of the old statewide system of outreach specialty clinics in 2004. Currently, six jurisdictions receive funds to partially support specialty clinics. Twelve (12) jurisdictions receive funds to support case management and care coordination. The need for respite care was mentioned in the needs assessment reports from most local health departments. Sixteen jurisdictions are currently (FY 2005) receiving funding for respite care.***

***/2007/ Prince George's County, one of the largest, most populous counties, is gearing up to apply for OGCSHCN funding for the first time in many years. Currently (FY 2006) 16 jurisdictions continue to be funded for respite care, 14 are funded for care coordination/case management and 5 jurisdictions are funded to provide 7 outreach specialty clinics. //2007//***

***/2008/ These numbers remained unchanged for FY 2007. //2008// /2009/ It is becoming increasingly difficult to maintain the infrastructure for outreach specialty clinics, care coordination, and respite care through the local jurisdictions with continued level funding of the Block Grant. Services are decreasing in most jurisdictions funded. //2009//***

Two Medical Child Care Centers are funded to serve children ages six weeks to three years of age with complex medical conditions and medical needs that cannot be met in traditional child/day care programs. As part of the interagency collaboration with Maryland's Early Intervention System, staff are involved in interagency coordination and liaison activities.

Finally, the Genetic Services Program coordinates a statewide network of clinical genetic services at 3 centers, and 13 general genetics outreach clinics. The clinic system is constantly rearranged to better serve the population in accordance with changing demographics in the state. Special genetics outreach clinics for facial clefts, hemophilia and sickle cell disease are conducted when there is need for them.

***/2009/ The clinical genetics program continues to operate as it has since 1981 but the State fiscal constraints see the Centers level funded at best. These grants have been level funded for years. With inflation, the fraction of operating costs born by the OGCSHCN is eroding. We are increasingly dependant on the Centers to bear an increasing fraction of the cost in order to continue services. The ability of the Centers to do that is also eroding and services may have to be cut. //2009//***

The Community Health Administration also administers a portion of Title V State matching dollars that are allocated to the local health departments through targeted funding. Maryland's 24 local health departments provide the core public health functions of assessment, policy development and assurance to citizens at the local level. The 24 local health departments receive annual basic public health funding (including Title V funds) from the DHMH through a Unified Grant Award process. Local health departments are the major service delivery arm for the DHMH and provide MCH services such as school health, family planning, home visiting and care coordination, immunizations, lead screening, fetal and infant mortality review, child fatality review, oral health services and maternal health services. Health Officers in each of Maryland's 24 jurisdictions are responsible for administering state and local health laws and regulations.

## **C. Organizational Structure**

The State of Maryland, Department of Health and Mental Hygiene (DHMH) is the designated Title V Agency. The Secretary of Health and Mental Hygiene, Mr. S. Anthony McCann, heads DHMH and reports directly to Governor Robert L. Ehrlich. Mr. McCann replaced Nelson Sabitini as the Secretary in September 2004. As the attached organizational chart shows, three Deputy Secretariats report to Mr. McCann: (1) Operations, (2) Public Health Services and (3) Health Care Policy, Finance and Regulations.

/2008/Mr. Martin O'Malley, the former Mayor of Baltimore City, was elected Governor in November 2006. Governor O'Malley appointed Mr. John M. Colmers as the Secretary of Health and Mental Hygiene in February 2007. An updated organization chart is attached.//2008//

***/2009/ Effective July 1, 2008, DHMH gained a fourth deputy secretariat, Behavioral Health and Disabilities as a result of legislation passed this year. Three Administrations that were formerly located under the Deputy Secretariat for Public Health - Alcohol and Drug Abuse, Mental Health and Developmental Disabilities - will comprise the new Deputy Secretariat. The aim of this reorganization is to enhance the Department's ability to coordinate these closely related programs. //2009//***

The Title V Program is administratively housed under the Family Health Administration within the Deputy Secretariat for Public Health Services. This Deputy Secretariat is responsible for six other administrations: AIDS, Alcohol and Drug Abuse, Community Health (e.g., Immunizations, sexually transmitted diseases, and bioterrorism), Developmental Disabilities, Laboratories, and Mental Hygiene; as well as the Anatomy Board and the Office of the Chief Medical Examiner. Medical Assistance, the State's Medicaid Program, is located under the Health Care Policy, Finance and Regulation Secretariat. The Deputy Secretariat for Public Services is headed by Dr. Michelle Gourdine.

***/2009/ Dr. Michelle Gourdine left State service in February 2008. Ms. Arlene Stephenson is currently serving as the Acting Deputy Secretary for Public Health Services. An updated organization chart is attached. //2009//***

The Family Health Administration (FHA) was formed in July 2001 and has been headed by Dr. Russell Moy as its Director and Ms. Joan Salim as the Deputy Director since its inception. FHA oversees a diverse array of public health programs within eight offices and two chronic rehabilitative facilities. The target population includes Maryland's total population of 5.5 million people, covering the lifespan from pregnancy to adulthood. Within the total population, at risk and vulnerable populations including low income, uninsured and medically underserved populations, are programmatically identified and safety net services provided. Dr. Moy reports to the Deputy Secretary for Public Health Services.

All of the MCH related programs are located within the FHA. The Family Health Administration includes the Center for Maternal and Child Health, the Office for Genetics and Children with Special Health Care Needs, the Office of Primary Care and the WIC Office. Other offices within the Administration closely linked with the core MCH offices are the Center for Preventive Health Services which recently gained administrative responsibility for the Office of Oral Health; Health Promotion, Education and Tobacco Control; and the Office of Health Policy. Department organization charts identifying the programs at the Secretariat and FHA levels are attached.

***/2009/ During 2008, the Family Health Administration has undergone several changes. First, the Office of Oral Health was re-established as a separate unit reporting to the Director of the Family Health Administration and a new State Dental Director was hired. Second, the Center for Preventive Health Services (CPHS) was disbanded and an Office of Chronic Diseases was created. The Injury Prevention and Public Health Surveillance components of the CPHS were merged with other existing offices. //2009//***

***An attachment is included in this section.***

#### **D. Other MCH Capacity**

Maryland's MCH Program includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. This team plans, manages, and monitors Title V activities for Maryland from the Downtown Baltimore offices of Maryland's State Office Complex. In addition, MCH staff in local health departments, including a cadre of community health nurses, physicians, program administrators and clerical personnel, are also supported by Title V funds.

The Center for Maternal and Child Health is headed by Bonnie S. Birkel, CRNP, MPH. Ms. Birkel is a trained nurse practitioner with a Master of Public Health degree and 25 years of experience in public health. She is responsible for MCH policy development and is official spokesperson for all MCH and family planning related areas. She has served as CMCH's Director since its inception in 2000.

Susan R. Panny, M.D., oversees the work of the Office for Genetics and Children with Special Health Care Needs. Dr. Panny is certified in both Pediatrics and Medical Genetics. She has 30 years of experience in pediatrics and genetics and 20 years of experience in public health. She is an internationally known figure in newborn screening and public health genetics. She has served as the Director of the OGCSHCN since 2000, and prior to that had served as Director of the Office for Hereditary Disorders since 1984.

Maureen Edwards, M.D., M.P.H., serves as Medical Director for CMCH. Dr. Edwards holds board certification in neonatology and a masters degree in public health. Her prime responsibility is to oversee and provide medical consultation on policy and assurance matters for various CMCH programs. She is also the Center's legislative liaison. Dr. Edwards supervises the Center's medical staff, including the Medical Director for School and Adolescent Health, Dr. Cheryl DePinto, who is board certified in pediatrics and adolescent medicine; the Medical Director for the Family Planning Program, Dr. Evan Mortimer, a board certified obstetrician/gynecologist; and the Medical Director for Women's Health, Dr. Diana Cheng, a board certified obstetrician/gynecologist.

/2008/ Dr. Maureen Edwards retired as Medical Director in August 2006. A new Medical Director is expected to be hired by September 2007.//2008//

***/2009/ Dr. S. Lee Woods, a neonatologist with a Ph.D. in genetics was hired as the new CMCH Medical Director in December 2007. Dr. Woods is the Center's chief spokesperson, and oversees the clinical and policy work of the Center. //2009//***

Jamie Perry, M.D., M.P.H. serves as the Associate Medical Director of the OGCSHN. Dr. Perry is board certified in Pediatrics and Neurodevelopmental Disabilities and holds a Master of Public Health Degree. Dr. Perry assists Dr. Panny in overseeing the clinical and programmatic work of the OGCSHCN, with particular focus on programs in the Division of Specialty Care.

Ngozi Nwokoro, PhD, MD was hired as a temporary consultant to the OGCSHCN to assist with the expansion of newborn screening. Dr Nwokoro has a PhD in biochemistry, is board certified in Pediatrics and has completed fellowships in clinical genetics and biochemical genetics. /2007/ Dr Nwokoro remained to follow up babies failing newborn hearing screening when that program lost all but one of its staff. She will stay in 2006 to assist with the legislatively mandated report on improving care for adults with sickle cell disease.//2007//

/2008/ Dr Nwokoro was reassigned to the newborn screening follow up program when the newborn screening follow up nurse retired.//2008//

Donna Harris, BS, serves as Special Assistant to the Director and Associate Director. Ms Harris tracks service data for programmatic purposes, handles data requests and produces special reports. She is in charge of OGCSHCN internal policies and assuring that OGCSHCN is in compliance with Departmental, State and federal policies and prepares reports documenting OGCSHCN compliance with all policies. /2008// Ms Harris is the OGCSHCN web-site coordinator and has assumed Dr Nwokoro's responsibilities with the adult sickle cell disease services steering committee. //2008//

In the CMCH, Bernadette Albers, M.P.H., APRNCS, assists Ms. Birkel as the Assistant Director of CMCH. Ms. Albers holds a Master of Public Health degree and is board certified in community health nursing. She has over 25 years experience in the fields of public health and health administration. In addition to being responsible for CMCH's daily operations, she supervises a unit that includes a master's trained health policy/research analyst who serves as the SSDI Project Director and Title V Coordinator (Yvette McEachern); a database administrator (Debbie Walpole); a master's trained asthma program administrator (Audrey Regan); a master's trained early childhood administrator (Mary LaCasse) and support staff (Debbie Krome and Anita Goldman).

***/2009/ Ms. McEachern now heads the Federal State MCH Partnership Unit that includes Title V coordination, SSDI, asthma and abstinence. //2009//***

/2007/ CMCH is undergoing a reorganization. In addition to serving as the Assistant Director, Ms. Albers is now responsible for supervising and managing three program areas: family planning and reproductive health; MCH systems development; and Community Partnerships. Ms. Astria Boyd-Millner was appointed Chief Operating Officer. //2007//

***/2009/ Ms. Boyd-Millner left CMCH in February 2008 and has been replaced by Ms. Sharon Houston. //2009//***

/2008/Ms. Bernadette Albers retired in December 2006. Her duties are currently being divided among three Section Chiefs.//2008//

/2007/ Audrey Regan was promoted to a newly created position, MCH Policy Analyst, and now reports to Ms. Birkel. A new asthma administrator, Rachel Hess-Mutinda, began work in July 2006. //2007//

***/2009/ Dr. Audrey Regan is now the Director of the Office of Chronic Disease Prevention. //2009//***

Until recently, this unit included four master's trained nurse consultants; however, two of them retired in the past year. The remaining two nurse consultants, Jeanne Brinkley and Pamela Putman, are responsible for monitoring local health department MCH contracts and providing technical assistance and consultation to Title V grantees on MCH issues (e.g., lead, adolescent health, asthma, obesity, school health). Ms. Brinkley supervises the MCH Coordination unit and the Department's lead staff person for lead activities. Ms. Putman also serves as the state's adolescent health coordinator. CMCH recently lost its fiscal administrator due to retirement. The Office is currently considering several options for filling this crucial vacancy.

***/2009/ Ms. Jeanne Brinkley retired and Pam Putman is now the Chief of MCH Systems Improvement. //2009//***

Planning, evaluation and data analysis activities are provided by a MCH epidemiologist, a MCH database specialist, a health analyst, the Assistant Director for MCH and the birth defects database specialist and nurse consultants in the OGCSHCN. Yvette McEachern, M.A. has served as the SSDI Project Director for the past three years and also oversees development of the Title V application including data collection, performance monitoring and needs assessment. Ms. McEachern has over 20 years experience as a health analyst/statistician. Debbie Walpole, B.S.

serves the MCH database manager/specialist and oversees CMCH database development and linkages; and data generation using SAS and other software. Bernadette Albers leads strategic planning efforts for the MCH Program and supervises grant development, including Title V.

William Adih, M.D., Dr.P.H. is a senior MCH epidemiologist with the Title V Program. Dr. Adih is a public health physician with extensive domestic and international experience in maternal and child health and reproductive health epidemiology. He provides epidemiological and data analysis support for the Center's activities. /2007/ Dr. Adih resigned in July 2006 to accept a position with the CDC. CMCH is recruiting a physician epidemiologist and hopes to acquire a third epidemiologist through the CDC MCH Epidemiology Program. //2007//  
/2008/Ms. Lee Hurt was hired as the new MCH Epidemiologist in 2007.//2008//  
**/2009/ A new full-time asthma epidemiologist, Linda Nwachukwu was hired in May 2008. //2009//**

Debra Perry, MPH was hired for a newly created Title X funded position of Family Planning Epidemiologist. Ms. Perry received her MPH from the University of Michigan School in of Public Health in Epidemiology and has worked provided epidemiologic support to various state and local agencies in Virginia and Maryland.

In addition, data support and analysis is provided by the Vital Statistics Administration which is headed by an MCH epidemiologist, Dr. Isabelle Horon, and the Office of Injury Prevention and Public Health Assessment which is headed by Dr. Lori Demeter. Contractual services are also purchased when necessary to complete data, assessment and planning activities.

Andy Hannon, LCSW-C, supervises the Division of Community-Based Initiatives and Partnerships. Mr. Hannon has over 25 years experience in public health and in addition to his supervisory role, leads male involvement initiatives for CMCH. Other activities under his direction include implementation of the PRAMS Survey which is supported by three staff persons (Helen Espatillier, Laurie Kettinger and Jodi Shaefer); and the Abstinence Education Program. The Abstinence Education Coordinator position is currently vacant and interviews have been held to select a new coordinator. This position serves as the Teen Pregnancy Prevention Coordinator for CMCH. Ms. Mary Johnson provides staff support to the Maryland Breastfeeding Promotion Task Force, and the Children's Environmental Health and Protection Advisory Council (CEHPAC). Ms. Johnson also leads community outreach efforts for CMCH. Joan Patterson, LCSW-C, was hired by Mr. Hannon as the CFR/FIMR Coordinator. She provides staff support to the State Child Fatality Review Team, and monitors contracts that provide technical support to local CFR and FIMR teams.

/2008/ Patricia Jones was hired as the Abstinence Coordinator.//2008//

/2007/ Mary Johnson was appointed as the State FASD Coordinator in 2005 and her CEHPAC responsibilities were transferred to Audrey Regan. Andy Hannon is now the Acting Chief of Family Planning. //2007//

**/2009/ Andy Hannon is currently on medical leave and Helene O'Keefe is the currently the acting director of Family Planning. //2009//**

The Title X Maryland Family Planning Program links and overlaps with MCH on a number of issues including preconception health care, teen pregnancy prevention and infant mortality reduction. The Family Planning staff include a Program Chief, a Medical Director, several physicians, several nurse practitioners who provide direct medical services and monitor contracts and program quality, and a program administrator. Ms. Victoria Young, LCSW-C, was hired the Chief of Family Planning in January 2003. Ms. Young has worked extensively in the area of child abuse and neglect.

In the OGCSHCN, Lynne Kelleher is chief of Program Support. She is the Chief Fiscal Officer and the Procurement Liaison for the Office. Sharon Burke handles contracts and assists with procurement. Barbara Greer handles personnel issues in addition to her role in the CMS program. General support services are provided by Marie Sapp, Terri Smiley and Chevria

Meekins. /2007/ Ms. Sapp retired and her duties were assumed by Ms Meekins. //2007// **/2009// Ms Kelleher left. Laura Weber, a former staff member has come out of retirement to take this position. //2009//**

The Division of Newborn Screening is directed by Karen L. Funk. BS, RN, MEd. Ms. Funk has 35 years of neonatal intensive care nursing experience. She provides the medically expert follow up for infants with abnormal blood spot screening results. She is also responsible for the major database of the OGCSHCN, which contains the linked data for the newborn blood spot and hearing screening programs, the long term follow up programs for sickle cell disease and metabolic disorders. Adi Bello, RN in the sickle cell disease program provides home visiting and clinical follow up and Marcia Diggs handles the sickle cell disease follow up database. /2008/ Sadly Ms Funk had to retire for health reasons and Dr Nwokoro assumed her responsibilities, assisted by Lucy Talbot, MA, a 2006 graduate of the University of Maryland Genetic Counseling program./2008// **/2009// A new chief of the Newborn Screening Division , Johnna Watson, RN , and a new genetic counselor, Carolyn Dinsmore, MA have been recruited.//2009//**

The Newborn Hearing Screening Program lost both its audiologists but two new audiologists are being recruited. The senior audiologist will serve as Chief of the Division of Newborn Hearing Screening Follow-Up. The junior audiologist will provide the expert audiological follow up of babies suspected of having hearing loss. Theresa Thompson, BA, MA and Carol Fernandez, BA provide initial follow up of hearing screening results and handle the educational aspects of the program. Eileen Cohen, BA, MA, CCC-SP, a speech pathologist who is the OGCSHCN Early Intervention specialist and the liaison with Medicaid, provides consultation to the hearing screening program. /2007/ Linda Vaughan, MA, CCC-A was recruited to direct the program but we were unsuccessful in retaining a junior audiologist. Ms Fernandez and her immediate successor both left. Recruiting continues. //2007// /2008/Erin Filippone, MA, CCC-A was recruited as second audiologist position and Stephanie Hood, BA as a follow up specialist. The infant hearing screening program is fully staffed for the first time.//2008//

Elizabeth Emerick, BA, MS, RD, LN and Mary Kalscheur, BA, MS, RD, LN are expert metabolic nutritionists, each with over 20 years of experience, and provide the dietary therapy and long term case management for children with metabolic disorders.

Anne Terry, BSN, MA, RN, serves as the Chief of the Birth Defects program. /2008/Rosemary Baumgardener, BA ,the database manager retired. /2008// **/2009/. Barbara Do, an intern is covering this position. //2009//**

Patricia Williamson, BSN, RN, CCM provides the clinical expertise for Children's Medical Services, the fee for service portion of the CSHCN program. Ms Williamson has 15 years of experience working with CSHCN and their families. Barbara Greer is the CMS eligibility specialist and Terri Smiley provides clerical support to this program. Joanne Johnson handles billing and assists Ms. Kelleher with the fiscal management of the Office. /2008/ Allyson Burlson-Gibson, MS was recently hired as the CMS Outreach Coordinator to work with both families and providers. She has a Master's in Human Services and is bilingual in English and Spanish. //2008//

Mary Ann Kane- Breschi, BA is the CSHCN regional resources coordinator and the liaison with the teaching hospital "Centers of Excellence", the local health departments, Parent's Place and other CSHCN family support services. Eileen Cohen oversees this portion of the program and directs the medical day care program. /2009/ Both Mrs Breschi and Ms Cohen have left and we are recruiting./2009/

/2008/ Rachel Hardegree, MPH was recently hired as the Medical Home Projects Coordinator. She is coordinating the OGCSHCN's medical home efforts and related projects. /2008//

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups

developed by the OGCSHCN and the continued grant support for Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. The OGCSHCN has two professional staff members who are mothers of CSHCN.

## **E. State Agency Coordination**

### State Agency Coordination

The attached organization charts identify the functions and staff that support Maryland's Title V Program. In addition, both MCH offices, CMCH and OGCSHCN, maintain strong collaborative relationships with other MCH serving agencies both within and outside of DHMH to support MCH service delivery and infrastructure. Within DHMH, strong partnerships and collaborations have been forged with key agencies directors and their staff. FHA partners include the Office of Health Policy (which now includes the federal Primary Care Cooperative Agreement), the Office of Primary Care and Rural Health, the Center for Preventive Health Services, the Women, Infants and Children's (WIC) Program, the Office of Health Program and Tobacco Use Prevention, the Center for Cancer Surveillance and Control and the Office of Oral Health.

Work on MCH issues and needs will continue to be coordinated with a number of key state agencies outside of DHMH either through collaboration on joint initiatives or through committees, task forces and advisory groups. These agencies include the Governor's Office for Children (formerly the Governor's Office for Children Youth and Families), the Maryland Department of Human Resources, the Maryland State Department of Education, the Department of Juvenile Services, the Maryland Institute of Emergency Medical Services, the Maryland Department of the Environment (MDE), and the Department of Housing and Community Development.

For example, several state agencies are responsible for planning and implementation of activities to eliminate elevated blood lead levels in Maryland children. MDE took lead responsibility for convening an Elimination Plan Working Group with representatives of state and local agencies (including DHMH), non-profits and community groups. A Maryland Plan to eliminate childhood lead poisoning by 2010 was developed. The Governor's Lead Commission on which CMCH is represented will oversee progress on Plan implementation.

Intra-agency and interagency collaboration will also continue with the following DHMH agencies and programs: the State Medicaid Agency, the Mental Hygiene Administration, the Laboratories Administration, the AIDS Administration, the Community Health Administration (including the Center for Immunizations), the Developmental Disabilities Administration, and the Maryland Health Care Commission.

MCH representation on numerous interagency councils, task forces, and committees will continue. These include the Coalition to End Childhood Lead Poisoning, the Governor's Lead Commission, the Promoting Safe and Stable Families Preservation Steering Committee, the Infants and Toddlers State Interagency Coordinating Council, the Maryland State School Health Council, various committees of the Maryland Chapter of the American Academy of Pediatrics, the Department of Human Resources Child Care Administration's Advisory Committee, Department of Human Resources' Responsible Choices Task Force, the Advisory Council for Hereditary and Congenital Disorders, the Advisory Council for Hearing Impaired Infants, the Advisory Board of Cooley's Anemia Foundation of Maryland, the Sickle Cell Disease Association of America, Neurofibromatosis Inc.-Mid Atlantic, the Maryland Alliance of PKU Families and the Maryland Hemophilia Foundation.

/2007/ and the Partnership for a Safer Maryland (Injury Prevention) //2007//

/2008/ Dr Panny from OGCSHCN was appointed to the Advisory Board of the Johns Hopkins Sickle Cell Center for Adults.//2008//

/2008/Dr. Audrey Regan is representing the MCH Program on BabyLAP, an Annie E. Casey Foundation supported initiative to reduce infant mortality in Baltimore City.//2008//

***/2009/ Dr Panny serves on the Statewide Steering Committee for Services for Adults with SCD.//2009//***

The private sector includes an array of birthing hospitals and centers as well as office-based obstetrical, pediatric, and primary care providers, managed care organizations, federally qualified health centers, and rural health networks. Specialty care needs are addressed through a network of community-based providers, tertiary care centers ("Centers of Excellence"), a genetics network, the Crenshaw network, and linkages with the Shriner's Hospital through the MCHB sponsored Choices Program.

The Title V agency will continue to strengthen its working relationship with non-governmental organizations including: the Medical and Chirurgical Society of Maryland (Med-Chi), the Maryland Chapter of the American Academy of Pediatrics, the American College of Medical Genetics, the Maryland Ob-Gyn Society, the University of Maryland Schools of Medicine, Dentistry, Nursing and Social Work, the Johns Hopkins School of Medicine, the Johns Hopkins School of Hygiene and Public Health, the Maryland Association of HMOs, Planned Parenthood of Maryland and Metropolitan Washington, the Maryland Hospital Association, the Maryland Association of County Health Officers and numerous other local voluntary and communication based organizations.

MCH programs have strong collaborative partnerships with several teaching hospitals/universities in the state. Both JHU and UMAB have collaborated in the development of state and multi state conferences, and the design of research projects. The GWU School of Public Health and the Johns Hopkins School of Public Health have established an internship relationship where graduate preventive medicine fellows, MPH candidates and/or nurse practitioners have practicum experience in the MCH offices. In addition, the Chief of Clinical Nursing at GWU serves as the liaison to Ryan White Title II and IV committees. Johns Hopkins Hospital, the Kennedy- Krieger Institute, the University of Maryland Medical Center and Children's National Medical Center partner with the OGCSHCN to deliver clinical genetic services as well as specialty care.

The Title V agency will continue to support community-based organizations that have been working to improve the health of mothers and children, including the Maryland Coalition for Healthy Mothers and Healthy Babies, the Maryland Perinatal Association, the Maryland chapter of the national March of Dimes Birth Defects Foundation, the Latino Community Health Care Access Coalition and numerous single disease oriented voluntary organizations.

/2008/Dr. Diana Cheng, Medical Director, Women's Health, CMCH, chairs the Maryland March of Dimes Grant Review Committee and is also a member of the Board of the Directors. Dr. Cheng is also a member of the Baltimore City Domestic Violence Fatality Review Team, a group that reviews cases of women who have died as a result of partner violence. //2008//

The Latino Community Health Care Access Coalition is a project of various Latino community groups, Catholic Health Care Initiatives, St. Clare's Medical Outreach, and St. Joseph Medical Center. Coalition members include the Highlandtown Medical Center, Johns Hopkins Bayview, Johns Hopkins Hospital, numerous Spanish speaking physicians in private practice and the Department of Health and Mental Hygiene, represented by Dr. Susan Panny of OGCSHCN. The goal is to assure access to high quality culturally competent health care for the Latino Community.

Other examples of collaborative efforts follow:

Inter-agency efforts with the WIC Program include the Maryland Breastfeeding Task Force and the Folic Acid Council. WIC and CMCH jointly co-chairs each of these groups. The March of Dimes is also an active participant in the Folic Acid Council. A grant from the March of Dimes to

the MCH Program allowed for the re-institution of the Folic Acid Council in 2003.

The Office of Oral Health (OOH) which was recently merged with the Center for Preventive Health Services has developed a strong collaborative relationship with the MCH Offices. The CMCH Assistant Director continues as an active consultant to the Statewide Oral Health Advisory Committee. This Committee is currently overseeing the completion of a study of Maryland's oral health infrastructure. The OOH works collaboratively with the Medicaid Program to complete an annual legislatively mandated assessment of use of oral health services.

/2007/ The Oral Health Advisory Committee was disbanded in 2005. CMCH and OGCSHCN participated in an Oral Health Institute sponsored by MCHB in May. One outcome of the Institute has been DHMH discussions around the need to establish a statewide Oral Health Coalition focused on the oral health needs of children. //2007// /2008/ A statewide Oral Health Coalition formed in the fall of 2006 and includes Title V representation.//2008//

Collaboration has been strengthened between the MCH program and the Family Health Administration's Center for Preventive Health Services on the issues of asthma, childhood obesity and women's health. In addition, the CMCH and Center on Health Education and Tobacco Prevention continues to partner with MCH, ACOG, and local health departments on smoking cessation initiatives during pregnancy.

The Title V Programs collaborate with other DHMH agencies on a number of priority MCH issues and needs. Intra-agency and inter-agency collaboration will continue with the following DHMH agencies, and programs: the State Medicaid Agency, the Mental Hygiene Administration, the Laboratories Administration, the AIDS Administration, the Community Health Administration (including the Center for Immunizations), the Developmental Disabilities Administration, the Vital Statistics Administration, Children's Environmental Health and Protection Council, the Office of the Chief Medical Examiner, and the Maryland Health Care Commission.

Maryland's Medical Assistance Program provides all the resources and personnel necessary to implement HealthChoice and MCHP. A collegial and collaborative relationship exists between this Program and the MCH Offices. A revised Memorandum of Agreement (MOA) was finalized in 2004. The MOA speaks to sharing of client databases between each unit, and access to information on Medicaid eligibility status. Examples of collaborative efforts include the drafting of the adolescent health section of the state's EPSDT Manual by two CMCH staff persons, the Medical Director for School and Adolescent Health, and the state's adolescent health coordinator. /2008/ The Maryland Medicaid program is currently collaborating with the OGCSHCN and the Maryland AAP in the ABCD Screening Academy, with a goal of making changes within the EPSDT Program to support improvements in developmental screening. A Developmental Screening Advisory Group has also been convened to oversee the ABCD project, and includes representatives from Medicaid MCOs, private insurers, specialty medical centers, pediatricians and family practitioners, Early Intervention, mental health, and family advocacy. /2008//

The OGCSHCN Early intervention specialist, who is a speech pathologist, spends two days a week with Medicaid preauthorizing OT, PT, audiological services, speech therapy and hearing aids. The OGCSHCN, particularly the CMS program, and Medical Assistance cross- refer patients that may be eligible for each others programs. The Medical Assistance information management staff produces reports of expenditures per child in the CMS program, broken down by county of residence and category of expense.

The new Interagency Agreement for Part C between the Department of Health and Mental Hygiene and the Maryland Department of Education includes a section on the exchange of data between OGCSHCN 's Newborn Hearing Screening Follow-Up program and the Division of Special Education/ Early Intervention to improve the referral process of hearing impaired infants to the Infants' and Toddlers' Program and to obtain long term outcome data on hearing impaired children identified through the newborn hearing screening program.

/2007/ Despite this agreement, additional more specific agreements will be needed to achieve the desired free exchange of information between the Newborn Hearing Screening Follow-Up program and the Maryland State Department of Education, Division of Special Education/ Early Intervention. // 2007// ***/2009//. Efforts at an MOU to exchange long term follow up information on infants with hearing loss with the Maryland State Department of Education continue to be unsuccessful. However, a reciprocal agreement was concluded with the Maryland School for the Deaf and we have ascertained that we can make direct referrals to the Early Intervention program so they can follow up on families referred who do not follow through. Apparently the conflict between HIPAA and FERPA are a national problem and were discussed at several national meetings.Perhaps help will come down from the national level./2009//***

The Center for Immunization within the Community Health Administration developed a strong collaborative relationship with the Division of Child and Adolescent Health to improve childhood immunization rates. MCH is represented on the Maryland Immunization Partnership Committee.

Mental health related issues and concerns such as improving access to services are critical to health of women, children and families in Maryland. The Title V Program has grappled with its role in this area and continually seeks opportunities to partner with other state and local agencies, advocacy groups, and community based organizations to improve the mental health of Marylanders. Mental health partners including child and adolescent health professionals in the Mental Hygiene Administration and the Mental Health Association were strategically involved in the latest statewide MCH needs assessment.

In May 2004, the Center for Maternal and Child Health in collaboration with the Mental Health Association of Maryland, Inc. submitted an application for the HRSA Grant entitled - Perinatal Depression and Related Mental Health Problems in Mothers and Their Families. Recent Maryland PRAMS data for 2003 indicate that at least 18% of new moms report being moderately or severely depressed following pregnancy. The state sought grant funds to implement a comprehensive public information and provider information campaign to increase understanding of perinatal depression and to address the stigma of mental illness which often discourages individuals from seeking treatment. Although the grant was not funded, educational materials including a postpartum depression brochure has been distributed widely throughout the state and requests for copies from other states have been honored. The MCH Program also partners with the State's Medical Society and the American College of Obstetricians and Gynecologists (ACOG) on postpartum depression.

/2007/ The Mental Health Association has received MCHB funding to implement - Healthy New Moms: Maryland's Campaign to End Depression During and After Pregnancy. Numerous outreach and education venues will be used to increase provider and consumer awareness of perinatal depression. Title V is collaborating with the Association and is an active participant on the Advisory Committee overseeing the Project. //2007//

The MCH Program continued as an active participant on the Early Childhood Mental Health Steering Committee. This inter-agency Committee was jointly convened by the Mental Hygiene Administration in DHMH and the Maryland Department of Education to develop a plan for incorporating mental health services into early childhood programs statewide. Both the Medical Director of CMCH and the Early Childhood Health Administrator are members. The state adolescent health coordinator is an active member of the planning committee for the Mental Hygiene Administration's annual statewide adolescent suicide prevention conference. CMCH is also an annual financial supporter of the conference.

Asthma is one the major causes of morbidity for Maryland children. Since 2001, CMCH has been administratively responsible for the state's CDC funded Asthma Grant which includes statewide asthma control planning and surveillance. With the completion of the Maryland Asthma Control

Plan in 2004, the Maryland Asthma Planning Task Force evolved into the Maryland Asthma Coalition. The Coalition meets quarterly, and advises the state on implementation of CDC funded asthma control activities for both children and adults. Coalition membership includes representatives of the clinical community (e.g., Johns Hopkins and University of Maryland Schools of Medicine), public health agencies at all levels (e.g., DHMH Center for Preventive Health Services), health organizations (e.g., Maryland Lung Association), physician organizations (e.g., American Academy of Pediatrics) community health centers, and educational authorities.

/2007/ Maryland is participating in an AHRQ sponsored Learning Institute to address racial/ethnic disparities in pediatric asthma. A team including representatives of Medicaid, local health departments, asthma providers, and the American Lung Association have been meeting to develop and implement a plan with technical support from AHRQ. //2007//

In the area of early childhood health, the MCH Program has also been represented on the following interagency groups: the Healthy Child Care Maryland Steering Committee, the Maryland Girl's Commission, the Healthy Homes Initiative, the Early Childhood Mental Health Steering Committee, the Ready at Five Strategic Planning Committee, The Judy Center Advisory Committee, the Maryland Home Visiting Collaborative, and TAMAR's Children (an intervention program for incarcerated women and their children that addresses infant bonding and attachment issues).

Since 2003, the MCH Program has been an active participant on the Leadership in Action Program (LAP) Team. This Team was convened by the Maryland Partnership for Children (includes the Secretaries of Health, Education and Human Resources) to address collaboration on early childhood issues in Maryland. MCH was also represented on the Early Head Start Policy Council and the Head Start Health Collaborative. MCH is also represented on the Maryland Developmental Disabilities Council, the Governor's Caregiver Support Coordinating Council, the Taskforce on Inclusive Child and After-School Care, and the Special Needs Advisory Council for HealthChoice and the Latino Community Health Care Access Coalition.

Several bills introduced during the 2004 Legislative Session would have required Maryland hospitals to provide written information to new parents on postpartum depression and shaken baby syndrome. The bills failed, however, and the Maryland Hospital Association subsequently convened an Ad Hoc Committee to determine how best to distribute this information to families of newborns. Both the CMCH Director, Bonnie Birkel and the CMCH Medical Director, Maureen Edwards are members of this Committee along with representatives from local hospitals and the Mental Health Association. The Title V Program is also represented on a statewide group that is developing a plan to address Fetal Alcohol Spectrum Disorders (FASD).

/2007/ The Maryland FASD Coalition was formed in 2005 with lead support from CMCH. //2007//

/2008/ A bill, HB 197 was passed in 2006 requiring the DHMH to prepare and distribute a brochure to inform expectant parents about cord blood donation. This brochure was developed and is about to be distributed. //2008//

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups developed by the OGCSHCN and their ongoing grant support of Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. The grants to Parent's Place also support a network of CSHCN parent representatives throughout the state. The OGCSHCN partnered with Wicomico County to establish a regional resource center in Wicomico County. The center serves the entire Eastern Shore and is a model for other regions. The center provides books, periodicals and internet access to information relevant to CSHCN and enables parents to access these resources and to link with other parents. /2009/ ***The OGCSHCN partnered with The Parents' Place of Maryland in an application for a State Implementation Grant for Integrated Community Systems for CYSHCN which was funded***

**by MCHB for the coming year. Other major partners in this Project are the Maryland Chapter, American Academy of Pediatrics and the Johns Hopkins Bloomberg School of Public Health. //2009//**

The OGCSHCN has two professional staff members who are mothers of special needs children and who bring the family perspective to the program. One serves as Chief of Regional Resource Development and the second is Chief of the Birth Defects Reporting and Information System.

Finally, the Title V Program will continue to chair and/or staff the following inter-agency advisory boards, councils and committees: the Perinatal Clinical Advisory Committee, the Perinatal Disparities Work Group, the Maryland Breastfeeding Promotion Task Force, the Early Childhood Health Advisory Committee, the Children's Environmental Health and Protection Advisory Council, the Asthma Coalition, the Women's Health/PRAMS Steering Committee, the State Child Fatality Review Team, and the Abstinence Education and Coordination Advisory Committee.

/2007/ The Breastfeeding Task Force has been reorganized into a statewide Breastfeeding Coalition. //2007//

/2007/ The Medical Director for Women's Health has published materials on the role of domestic violence in maternal mortality and represents Title V on the following groups: the Baltimore City Domestic Violence Fatality Review Team (reviewing homicides due to domestic violence; the Maryland Domestic Violence Advisory Board (coordinated by the Medical Society to promote domestic violence awareness); the AMCHP MCH Violence Prevention Advisory Group (promoting a learning lab in perinatal domestic violence). //2007//

/2007/ Title V is working with the Maryland Health Professional Education Committee, established by the Office of Minority Health and Health Disparities, to increase the cultural competency of the health professional work force. //2007//

**/2009/ The Medical Director for Child and Adolescent Health has been asked to participate on a Youth Development Learning Collaborative sponsored by the Governor's Office for Children (GOC) to promote positive youth development. She is also a member of the Ready by 21 Consortium being spearheaded by the GOC. //2009//**

**/2009/ CMCH is a member of the School Health Practice Committee that has been meeting recently to revise communicable disease guidelines for schools and child care. //2009//**

**/2009/ The OGCSHCN Director serves on the Statewide Steering Committee on Services for Adults with SCD.//2009//**

## **F. Health Systems Capacity Indicators**

### **Introduction**

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	45.0	41.5	34.2	35.4	40.9
Numerator	1641	1556	1303	1303	1507
Denominator	364507	374578	381487	368199	368199
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

#### **Notes - 2007**

Source: Hospitalizations - MD Hospital Discharge Database, 2006; Population - MD Vital Statistics Population estimates for 2006; 2007 estimates are currently unavailable.

#### **Notes - 2006**

Source: Hospitalizations - MD Hospital Discharge Database, 2006; Population - MD Vital Statistics Population estimates for 2006.

#### **Notes - 2005**

Estimate based on 2004 data since 2005 data is currently not available.

#### **Narrative:**

The State's ability to address asthma from a public health perspective has been influenced by legislation mandating creation of a State Asthma Control Program and CDC funding to support asthma control activities. The MCH Program with the support of asthma stakeholders completed a planning process that resulted in the development of a State Asthma Plan that identifies strategies and action steps for improving asthma outcomes.

In 2002, the Maryland Legislature mandated that a Maryland Asthma Control be established within the Department of Health and Mental Hygiene and charged the Program to develop a statewide asthma surveillance system and an asthma control plan. The Program's goals are to: (1) decrease the prevalence of asthma and the occurrence of its complications in Maryland; and (2) decrease disparities in health outcomes related to asthma in all parts of the State. Since 2002, with the assistance of a CDC Asthma control grant, the Program has developed an asthma plan (with support from Asthma Coalition members), built a surveillance system, and begun to implement initiatives in an effort to address Program goals. Asthma Control Program funding is supplemented by the Maternal and Child Health Block Grant.

Surveillance is the cornerstone of the Maryland Asthma Control Program. Analysis includes prevalence, emergency department visit rates, hospitalization rates, mortality rates, health disparity assessment, asthma-related health behaviors, and asthma-related health care costs. To date, four annual asthma surveillance reports have been completed for the years 2002-2005. The 2005 Maryland Asthma Surveillance Report (most recent report available) indicates that statewide, an estimated 142,270 children have been diagnosed with asthma at some point in their lifetime. This represents 10.2% of children. An estimated 106,000 children (7.6%) currently have asthma. Children under the age of 5 had the highest hospitalization rate of any age group at 43.4 hospitalizations per 10,000 population in 2005. Maryland's rate was lower than the national average in 2003, but higher than Healthy People 2010 goal of 25 hospitalizations per 10,000. Hospitalization rates for African Americans in 2005 were three times that of Whites. The emergency department visit rate was four times higher for African Americans as compared to Caucasian Americans.

Maryland's SSDI Project Team works collaboratively with the State's asthma surveillance team to complete annual asthma surveillance reports and issue briefs. Future plans include using GIS mapping to identify asthma "hot spots" within the State and to further analyze BRFSS and other datasets to assist in addressing racial and ethnic disparities.

***//2009/ A new full-time asthma epidemiologist began working with the Asthma Control Program in April 2008. The epidemiologist is currently working with Project staff and staff in the Department of Education to improve school based asthma surveillance in the State. The 2006 and 2007 Asthma Surveillance reports are currently being prepared. //2009//***

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	90.6	85.7	85.9	86.0	87.9
Numerator	28794	27838	28799	30488	32206
Denominator	31778	32491	33517	35450	36639
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Source: Maryland Medicaid Program. Defined as those born between 1/1/7 - 9/30/07. Initial periodic screen defined as CPT code 99381; 99391; 99341 or diagnosis codes starting with v20.2; v77.0; v77.9; v78.0-v78.9.

**Notes - 2005**

Source: Maryland Medicaid Program. One time data for 9/30/2005.

**Narrative:**

Data for this indicator is provided by the Medicaid Program. Increasing percentages of infants enrolled in Medicaid are receiving at least one periodic screen. **//2009/ In Federal Fiscal Year 2007, 88% of the 36639 infants enrolled received a screen; up from 75% in FFY 1999. //2009//**

Maryland's EPSDT Program is known as the Healthy Kids Program. The Program's goal is to promote preventive health care services for children to promote early identification and treatment of health problems before they become medically complex and costly to treat. Standards for the Healthy Kids Program are developed in collaboration with the Title V Agency and other key MCH stakeholders such as the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, and the Maryland Department of the Environment. The "Maryland Schedule of Preventive Schedule of Preventive Health Care" closely correlates to the American Academy of Pediatrics' periodicity schedule.

Most infants are enrolled in HealthChoice, Medicaid's managed care program which began in 1997. Medicaid recipients enroll in a managed care organization of their choice and select a primary care provider to oversee their medical care. The HealthChoice Evaluation data for 2006 indicates that the percentage of infants (includes those enrolled in both traditional Medicaid and MCHP) receiving a well child visits increased between 2000 and 2003, from 69.2% to 79.4%. Well child visits were defined by Medicaid to include well child visits, EPSDT and preventive services.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	91.4	73.3	73.3	52.6	83.9
Numerator	361	211	211	201	433
Denominator	395	288	288	382	516
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Source: Maryland Medicaid program data for FFY 2007. Infants defined as those born between 10/1/07 to 9/30/07.

**Notes - 2005**

2005 data was not available. Estimate is based on 2004 reporting.

**Narrative:**

Maryland's SCHIP Program, the Maryland Children's Health Program (MCHP), provides full Medicaid health benefits to children up to age 19, and pregnant women of any age who meet the income guidelines. MCHP enrollees obtain care from Managed Care Organizations (MCOs) through the Maryland HealthChoice Program.

*//2009/ The Medicaid Program reports that in FFY 2007, 84% of the 516 infants enrolled received at least one periodic screen. The Medicaid Program is currently investigating to determine if the decrease between 2004 and 2006 is real or the result of a change in the methodology used to determine progress on the indicator. //2009//*

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0.0	70.1	70.1	70.1	69.4
Numerator	0	52224	52491	54275	54146
Denominator	1	74500	74880	77430	78054
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2006**

The identified data was obtained from the March of Dimes Peristats Website. It reflects data for Maryland that estimates that 70.1% of women received adequate or adequate plus prenatal care according to the Kotelchuck Index in 2004. This percentage was applied to 2006 births.

#### **Notes - 2005**

Data from the Vital Statistics Administration was requested but was not provided because of concerns about the formula used to calculate the Kotelchuck Index. The formula defines the first trimester of pregnancy as months one through four. Months one to three is the traditional definition of the first trimester.

The identified data was obtained from the March of Dimes Peristats Website. It reflects data for Maryland that estimates that 70.1% of women received adequate or adequate plus prenatal care according to the Kotelchuck Index in 2004. This percentage was applied to 2005 births.

#### **Narrative:**

Maryland recently began to analyze the data to be able to monitor progress on this indicator. The data show that only 70% of Maryland moms are receiving adequate prenatal care according to the Kotelchuck Index. Early prenatal care in Maryland have been declining for the past several years which is a cause of concern for the Title V Program in combination with the low score on the Kotelchuck Index. This year through both the Title V needs assessment and the new Babies Born Healthy Initiative, the MCH Program plans to explore in depth the slide in prenatal care rates and to develop an action agenda that includes both community based and institutional level strategies to address the problem. CMCH plans to hire a new MCH epidemiologist to aid in spearheading this effort.

***/2009/ Under the Babies Born Healthy Initiative, in 2009, CMCH is planning to expand outreach and case management services to low income at risk women in Baltimore City. Funding is being awarded to Baltimore City's Healthy Start, Inc. (BCHSI), a community based group that provides enabling services to pregnant and post-partum women in at-risk communities. BCHSI will expand their preconception and interconception health services into four additional Baltimore City communities. They received support to conduct a needs and capacity assessment to determine where and what kind of services were most needed from the Title V Program.***

***Despite this expansion effort, cuts in Medicaid funding for home visiting and care coordination services linking women to prenatal care and other resources are making it more difficult for Baltimore City and other at risk jurisdictions to promote access to prenatal care services. The Title V Program is working with Medicaid to monitor the effects of these cuts. //2009//***

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	77.3	78.9	79.5	80.7	83.6
Numerator	286398	317803	321369	324114	317571
Denominator	370303	402825	404286	401816	379937
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Narrative:**

The Maryland Medicaid or Medical Assistance Program provides health insurance coverage for eligible low income Marylanders. In FY 2006, more than 400,000 eligible children and teens under the age of 20 were enrolled. MCHP, the State's SCHIP program, is also administered by the Maryland Medicaid Program. Eligibility requirements include living in families with incomes up to 300% of the federal poverty level. In FFY 2007, there were children 144,751 enrolled.

The majority of children enrolled in either Medicaid or MCHP are required to participate in HealthChoice, Maryland's statewide mandatory managed care program which began in 1997. Eligible Medicaid recipients enroll in a Managed Care Organization of their choice and select a Primary Care Provider to oversee their medical care. Covered services for both Medicaid and MCHP include EPSDT and dental services for children.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	48.0	48.7	48.7	51.6	46.7
Numerator	26593	28071	28071	32065	44600
Denominator	55425	57589	57589	62166	95464
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Source: Maryland Medicaid Program, calendar year 2007. Age as of 1/1/07.

**Notes - 2006**

Source: Maryland Medicaid Program. In calendar year 2006, there were 62,166 children enrolled in HealthChoice managed care organizations for at least 320 days. 32,065 of these children had at least one dental visit.

**Notes - 2005**

Data for 2005 was not available. Estimate is based on 2004 data.

**Narrative:**

Many Marylanders were shocked in early 2007 when a 12 boy year died because he did not have access to good dental health care. The young boy died when bacteria from an abscessed tooth spread to his brain. His mother noted that his Medicaid coverage had lapsed, but even while on Medicaid she had experienced difficulty in finding a dentist willing to treat her son. The 2007 Maryland Legislature took note of this tragedy and in 2007 passed an Oral Health Safety Net bill

to fund oral health delivery services in local health departments and community health centers. Unfortunately, the bill passed with no funding appropriated for implementation.

In 1998, Senate Bill 590 passed and established the Office of Oral Health within the Department of Health and Mental Hygiene's Family Health Administration. It required DHMH to develop a five year oral health care plan that set targets for Medicaid MCO enrollee's access to oral health services. The Bill also requires DHMH to annually report on the availability and accessibility of dentists participating in the Program, outcomes in reaching utilization targets, and how funds were used.

The latest report issued in October 2006 identified the following:

- . As of July 2006, there were approximately 918 dentists enrolled as providers. This represents an improvement but still indicates that less than 20% of the State's dentists participate.
- . Other enrolled providers include 12 local health department provider sites and 13 federally qualified community health center sites.
- . In 2005, 46% of enrolled children received one or more dental services. Most received either diagnostic (43%) or preventive (40%) services; only 16% received restorative services.
- . Medicaid Managed Care Organizations have attempted to increase oral health services use by:
  - Sending reminders to members about the importance of dental care.
  - Developing incentive programs to induce participation.
  - Providing dental education awareness programs in schools.
  - Meeting with providers to address and respond to concerns.

***/2009/ Based on the recommendations of a Dental Action Committee convened by Secretary Colmers in 2007, the Maryland Legislature appropriated \$16.1 in FY 2009 to implement a number of recommendations made by the Committee. These include increasing Medicaid dental reimbursement rates, providing grants to local health departments, federally qualified health centers and others to improve access to dental care and expanding school based dental services through use of a dental van. CMCH is working with the Medicaid Program to examine and explain the dental in dental care use./2009/***

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	14039	12246	14720	15275	13246
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

This annual indicator is zero. The OGCSHCN is currently only able to track this data in the Children's Medical Services Program, and only two SSI beneficiaries less than 16 years of age received services from this program in 2007. Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2007 from the Social Security Administration.

**Notes - 2006**

This annual indicator is in fact zero. The Title V CSHCN program does not want to pay for care for SSI beneficiaries when they can receive this care through Medicaid. Denominator data is the number of Maryland children ages 0-17 receiving SSI as of December 2006 from the Social Security Administration.

**Notes - 2005**

This annual indicator is in fact zero. The CSHCN program does not want to pay for care for SSI beneficiaries when they can receive this care through Medicaid. Denominator data is the number of Maryland children receiving SSI as of December 2005 from the Social Security Administration.

**Narrative:**

According to the Social Security Administration, as of December 2006, there were 15,275 Maryland children ages 0-17 years receiving SSI. In 2006, none of these children received rehabilitative services from the Title V CSHCN Program. Maryland Medicaid provides comprehensive services, including rehabilitative services, and all of these children qualify for Maryland Medicaid programs. There is no mechanism for tracking SSI-eligible children who do apply for Medicaid. In addition, the Maryland Title V CSHCN program currently only provides rehabilitative services through Children's Medical Services (CMS), payer of last resort for uninsured/underinsured CYSHCN. No SSI beneficiaries received services through CMS in FY06. ***//2009/ As of December 2007, there were 13,246 Maryland SSI beneficiaries less than 16 years of age. Only two Maryland SSI beneficiaries less than 16 years of age received services through the Children's Medical Services Program in 2007. //2009//***

**Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)**

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	11.3	8.5	10.3

**Narrative:**

***//2009/ In 2006, 11.3% of Maryland babies were born prematurely or too early (under 37 weeks gestation). Premature babies are more likely to die within the first year of life than full term babies. Premature babies are also more likely to be born at low birth weights putting them at risk for numerous medical and handicapping conditions. Prematurity and low-birth weight are the leading causes of infant deaths in Maryland. Risk factors for prematurity or low birth weight include medical conditions and complications as well as behavioral/social factors such as maternal smoking, maternal weight gain and late entry into prenatal care. The increase in the state's infant mortality rate between 2002 and 2004 was partially the result of an increase in the number of very low birth weight infants born. In 2006, 88% of very low birth weight infants born in Maryland were delivered at high-risk facilities.***

***In 2006, over 6,000 Maryland babies (10.3%) were born at low birth weights (less than 2,500 grams). That same year, 1,415 (1.9%) of babies were born at very low birth weights (less than 1,500 grams). Maryland has much work to do to reach the Healthy People 2010 goals***

***for low birth weight (5%) and very low birth weight (0.9%). //2009//***

Maryland's low birth weight rate has consistently been higher than the national average (9.4% for MD and 8.1% for U.S. in 2004). The percentage of infants born at low birth weight increased in Maryland and the U.S. throughout the nineties. Factors contributing to the increase include an increase in multiple births, which are more likely to be delivered preterm, and/or at low-birth weight. In 2005, 58.8% of multiple births included babies born at low birth weights as compared to 7.2% of live singleton births. However, low birth weight rates have also been increasing among singleton births.

The low birth weight rates for American Indians and African Americans in 2006 were significantly higher than that of other racial and ethnic group. African American (13.2%) babies were more likely than Caucasian (7.1%), Hispanic (7.2%) and Asian (8.1%) babies to born at low birth weights. Five jurisdictions had low birth weight rates considerably above the statewide average of 9.2% in 2006: Baltimore City (13.2%), and Dorchester (12%), Allegany (11.6%), Prince George's (10.5%), and Kent (10.5%) counties. Women enrolled in Medicaid were more likely to give birth to a low birth weight baby than women with other types of coverage.

The Title V Agency works with local health departments, the March of Dimes, state medical associations, advocacy groups, hospitals and community based organizations to improve births and reduce adverse outcomes such as low birth weight.

***//2009/ In 2009, the Babies Born Healthy Initiative will work with health providers, local agencies and community based groups to reduce the State's low birthweight rate. In April 2008, the Department of Health and Mental Hygiene reconvened the Perinatal Clinical Advisory Committee (PCAC). The Perinatal Clinical Advisory Committee is a multidisciplinary committee representing 20 Maryland professional organizations and is charged with reviewing and updating the Maryland Perinatal Systems Standards. The PCAC will review the current guidelines to ensure they are consistent with the Guidelines for Perinatal Care, 6th Edition, 2007 issued by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists. //2009//***

**Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	payment source from birth certificate	8.5	6.6	7.2

**Notes - 2009**

Source: Linked birth/infant death file for 2005.

**Narrative:**

***//2009/ Data for this indicator is derived from linked birth and infant death records for 2005 (2006 linked data is currently unavailable). As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly more likely to have a baby die within the first year of life.***

***The Babies Born Healthy Initiative will buildson preventive health strategies for reducing infant mortality, as supported by the literature and Maryland's successful experience with***

*reducing infant mortality in the 1990's.*

*Strategies include MCH-WIC Collaborative Projects in Baltimore City, and Baltimore, Charles, and Wicomico Counties where MCH services (including family planning, folic acid distribution, and others) are linked with WIC services to maximize women's health during the preconception and interconception period, which is key to positive birth outcomes. Another strategy is the Maryland Advanced Perinatal System Support (MAPSS) Project. This University of Maryland Program provides telemedicine linkages between high-risk obstetrical consultants and local providers and three hospitals. This is necessary because there is a shortage of obstetrical providers throughout the State, and MAPSS supports local providers, which enables them to stay in practice.*

*Patient safety has become a national priority as a result of the groundbreaking Institute of Medicine Report entitled "To Err is Human." Some infant deaths in Maryland are attributable to patient safety concerns. In partnership with the Maryland Patient Safety Center's (MPSC), the Perinatal Collaborative is bringing together 25 Maryland hospitals to advance patient safety. Hospitals are improving communication, enhancing education, and establishing safety-related protocols. All 25 hospitals are submitting data into a single database at the National Perinatal Information Center. This phase of the collaborative will end with a results congress in May. We have already begun discussing continuation of the collaborative with a focus on NICUs for FY 2010. //2009//*

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	66.6	94.2	81.7

**Narrative:**

Data for this indicator is derived from birth records for 2006. Linked birth and Medicaid files were unavailable. As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly less likely to receive early prenatal care. Early prenatal care rates have continued to decline for both Medicaid and non-Medicaid women over the past decade. National performance measure #18 discusses state activities directed at improving this situation.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

<b>indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	60	74.9	69.4

**Notes - 2009**

Source:

**Narrative:**

Maryland recently began to analyze the data to be able to monitor progress on this indicator. The data show that only 70% of Maryland moms are receiving adequate prenatal care according to the Kotelchuck Index. Early prenatal care in Maryland have been declining for the past several years which is a cause of concern for the Title V Program. This year through both the Title V needs assessment and the new Babies Born Healthy Initiative, the MCH Program plans to explore in depth the slide in prenatal care rates and to develop an action agenda that includes both community based and institutional level strategies to address the problem. CMCH plans to hire a new MCH epidemiologist to aid in spearheading this effort.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

<b>INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2007	185
<b>INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2007	300

**Narrative:**

The Maryland Medicaid Program provides medical care coverage to low income infants, children and pregnant women. Pregnant women and infants are covered up to 185% of the poverty level. SCHIP coverage extends to 300% of the poverty level for infants. Families of enrolled infants with incomes between 200% and 300% pay a premium based on a sliding scale.

*//2009/ Maryland continues to have one of the most expansive Medicaid Programs in the country. //2009//*

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children	2007	

(Age range 1 to 19) (Age range to ) (Age range to )		100
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 19) (Age range to ) (Age range to )	2007	300

**Narrative:**

Medicaid eligibility coverage extends to pregnant women and infants with family incomes up to 185% of the poverty levels. Coverage for children and adolescents extends to families with incomes up to 100% of the federal poverty level (FPL).

*/2009/ Maryland's MCHP Program is one the richest in the nation in terms of the types of services covered as well as income eligibility. //2009//*

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2007	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	250

**Narrative:**

Maryland's state only MCHP Program provides coverage to eligible women with family incomes up to 250% of the poverty level. Children in families with incomes up to 200% of the poverty level are eligible for MCHP. The MCHP Premium Program provides coverage to uninsured children and adolescents children up to age 19, who have not dropped employer-sponsored health insurance within the previous six months, and who have paid the monthly premium payment per family. The family income standard for eligibility is at 200% through 300% of the FPL. Premiums vary by family size and income and range from \$41 to \$52 per month. For both, MCHP and MCHP Premium, assets are not considered in determining eligibility. In addition, MCHP and MCHP Premium beneficiaries receive health benefits through HealthChoice, Maryland's Medicaid Managed Care Program.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
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<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

#### **Notes - 2009**

#### **Narrative:**

The MCH Program now has access to timely population based and program data from several sources. Maryland has established and is working on improving routine access to six of the nine linked data sets and surveys identified in Title V Block Grant Health Systems Capacity Indicator #9(A): 1) the annual linked birth-death certificate database, 2) a linked birth and newborn screening file; 3) birth defects surveillance system, 4) the hospital discharge database, 5) the Pregnancy Risk Assessment Monitoring System (PRAMS), and 6) the Youth Risk Behavior Surveillance System (YRBS). Analyses and reports generated from these databases have been used to conduct surveillance, develop MCH reports and enhance MCH program and policy development. In addition, the MCH Program has been working with Medicaid to gain direct access to a Medicaid database, on an as-needed basis. This connection is being utilized to link Healthy Kids data with information from the Medicaid managed care enrollee database for a study on childhood obesity.

Maryland became a PRAMS state in 1999 and released its first PRAMS Report covering 2001 births in April 2004. PRAMS reports for the 2002-2005 birth cohorts have been completed. PRAMS data will be used to track and monitor several state and national performance measures including unintended pregnancy and breastfeeding; and to conduct in-depth analyses to guide planning for perinatal systems building.

Since the mid-1990's, Maryland's SSDI Project has focused on improving epidemiologic and data capacity at the State level; strengthening the State's ability to assess annual targets for Title V performance measures; and improving State and local capacity to assess and prioritize needs, develop annual plans, and monitor program performance.

*/2009/ Maryland continues to negotiate with WIC and the Vital Statistics Administration to obtain electronic access to files relevant to MCH data analysis and needs assessment.  
//2009//*

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes
Cigarette Restitution Fund Tobacco Survey	3	No
Maryland Adolescent Survey - Dept. of Education	3	No

**Notes - 2009**

**Narrative:**

Maryland used funds received from the tobacco settlement to establish the legislatively mandated Tobacco Use Prevention and Cessation Program. The Program was required to collect baseline data on tobacco use habits among youth (middle and high school students) and adults at the state and local levels. These surveys were to be repeated at least every other year for use in monitoring achievement of program goals. Baseline data for the Maryland Youth Tobacco Survey was collected in the fall of 2000. A second survey was completed in the fall of 2002. The surveys show that tobacco use by youth attending public high schools declined from 23% in the fall of 2000 to 17.6% in the fall of 2002. State budget cuts delayed completion of the next round of surveys until 2006.

The Maryland Adolescent Survey (MAS) is jointly sponsored by the State Departments Education; and Health and Mental Hygiene. Every two years, a sample of sixth, eighth, tenths and twelfth graders are surveyed to determine trends the use of alcohol, tobacco, and other drugs among adolescents. The most recent survey in 2004 was completed by 33,979 students and represented 12 to 14% of the State's public school enrollment. Reported findings included reductions in thirty day tobacco use rates for tenth and twelfth graders. Maryland become a YRBS state 2004. Students completed the first survey in April 2005 and the State completed its first report in 2006. A second YRBS survey was completed this past schoool year.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

This section describes Maryland's progress on required national and state performance measures and documents accomplishments, current activities and the State's plan for FY 2009. In many cases, the most current available data is for calendar (CY) or state fiscal year (FY) 2006. Therefore, for many performance measures, we were unable to report on progress for FY 2006. In several instances, the data for the year 2007 will not be available until the fall of 2007 or later. As this data becomes available, it will be incorporated into subsequent applications.

In FY 2007, Maryland's Title V Program served approximately 213,159 pregnant women, infants, children, including those with special health care needs and adults. As this report will show, Maryland was able to meet or surpass many of its target objectives for the state's 33 performance and outcome measures. Conversely, measures such as the continued decline in the early prenatal care rates remain as a challenge.

Maryland's MCH Program seeks to improve and enhance the health of all Maryland women, infants, and children including those with special health care needs through funding of Title V and state supported activities and programs. The Program's vision includes a State in which: all pregnancies are planned, all babies are born healthy, all children including those with special needs reach an optimal level of health, and all women and children have access to quality health care services. Title V activities discussed in this document are designed to reflect this vision.

Activities and services are delivered at each level of the MCH pyramid and directed at each of the Title V population groups: pregnant women and infants, children and adolescents, and children with special health care needs. Reducing infant and child mortality and improving health outcomes are Program priorities as described in the next section. All activities and programs are linked to these outcome measures.

### **B. State Priorities**

Below are Maryland's 8 priority needs identified, as required, as part of the state's 2005 Needs Assessment process. Please note that while the 2005 priorities are numbered, the assigned numbers do not reflect their importance. Consideration was given to multiple factors in selecting Maryland's 2005 MCH priority needs. These included findings from a review of data trends and analyses; focus group comments; local health department surveys and meetings; the CAST -- 5 capacity assessment and input from Title V Program staff and other MCH serving agency staff in DHMH.

1. To eliminate racial and ethnic disparities in maternal and child health.

Over the past two decades following the publication of national and state reports (e.g., the 1987 Maryland Governor's Commission on Black and Minority Health), awareness has been raised about racial and ethnic disparities in health. Both the Maryland Department of Health and Mental Hygiene and the Title V Program are committed to eliminating health disparities. DHMH was also recently mandated by the state Legislature to create an Office of Minority Health and Health Disparities. Racial and ethnic disparities were identified as a priority area during the last comprehensive needs assessment remain as a priority for the 2005 needs assessment.

Maryland data consistently reveal substantial racial and ethnic disparities on numerous key indicators of health and access to health care including infant and child mortality. The research literature is increasingly recognizing that social factors including poverty, and discrimination contribute significantly to these disparities. Maryland has begun to look at the role of stress and racism as a stressor in poor birth outcomes for African American babies. The role of public health

in addressing social issues that normally have been viewed as issues that fall outside of our rubric will be considered over the next five years as Maryland attempts to address persistent, yet amenable disparities within its maternal and child health population. Technical assistance will be provided to local health departments and other MCH serving agencies within DHMH to address this priority.

The selected state performance is the percentage of jurisdictions with written plans to address racial/ethnic disparities in MCH. A related national outcome measure is the ratio of Black infant deaths to white infant deaths. A concerted effort will be undertaken to determine the causative factors of key disparities, including maternal and infant mortality, and asthma morbidity.

2. To promote healthy pregnancies and healthy pregnancy outcomes.

As part of its mission statement, Maryland's Title V Program envisions a future in which all pregnancies are planned, all women reach an optimal level of health and well-being prior to pregnancy, no woman dies or is harmed as a result of being pregnant, and all babies are born healthy. Results of the 2005 Needs Assessment indicate that much work remains to be done if this future is to be realized for all mothers and babies. The majority of babies in our state are born healthy to healthy mothers who experience healthy pregnancies. However, Maryland continues to have one of the nation's highest infant mortality and low birth weight rates. The health disparities identified in priority #1 partially contribute to this finding.

Two state performance measures have been selected to address this priority: (1) Percentage of pregnancies intended, and (2) Percentage of women using alcohol during pregnancy. This priority is directly linked to the infant mortality outcome measure as well as performance measures # 8, 15, 17 and 18.

3. To promote optimal family functioning.

Throughout the five year needs assessment, we heard about the need to support and strengthen families to assure that children remain healthy and thrive. This need for support is cross-cutting and required for all Maryland families, especially socio-economically disadvantaged families. However, the Title V Program also recognizes that families of children with special health care needs are especially vulnerable and in need of services that enhance their ability to care for their children and address their need for supportive services such as respite and child care.

Many Maryland families were anecdotally described as "in crisis or in peril." We heard that families are disconnected; parents are stressed and overwhelmed with the process of parenting as well as accomplishing the tasks of daily living; parents are placing demands on their children to be "successful;" children are being abused and neglected; and parental substance use is a growing problem. Family support can take many forms including parenting classes; affordable quality child care; mental health counseling programs; and substance abuse treatment programs. Over the next five years, the Title V Program will promote optimal family functioning by partnering with other MCH serving agencies, families, and communities to develop and implement policies and programs that promote optimal family functioning for all families.

4. To promote healthy children.

Similar to 2000 needs assessment findings, both qualitative and quantitative data continued to reveal unacceptable levels of morbidity and mortality among children in the early and middle childhood periods. Areas of continuing concern included asthma, overweight and obesity, dental caries, mental health related problems, and child abuse and neglect. This priority was selected to ensure continued focus on improving the health of children in the early and middle years. For example, asthma currently affects more than 100,000 Maryland children and it is the leading cause of hospitalization for children in the elementary and middle school years as well as leading reason for school absenteeism. Asthma is a controllable disease when properly managed. The

use of hospital emergency departments for routine asthma management can be an indicator of poor asthma management. The Maryland Asthma Control Program which is administratively housed in the Center for Maternal and Child Health is implementing a statewide plan to reduce mortality and morbidity from asthma by promoting educational and other to improve asthma management. The emergency department use rate due to asthma will be used as one the state performance measures for this priority.

This priority was also chosen because of the relationship between health, school readiness and school performance. The Center for Maternal and Child Health is the recipient of an MCHB funded Early Childhood Comprehensive Systems Grant. This funding is being used to develop a plan for promoting school readiness by improving the health of young children in Maryland through early childhood systems building and collaboration. The second state performance measure for this priority is the percentage of students entering school ready to learn.

5. To promote healthy adolescents and young adults.

Adolescence, however it's defined (ages 10 -- 19 or 12-19 or 13-24), is a time of tremendous change and growth. This transitional developmental period between childhood and adulthood offers many physical, mental and emotional challenges. Risk taking is the norm during this period. Many adolescents make the transition to adulthood with few problems, others do not fare as well. Focus groups with parents and service providers consistently identified the need to promote healthy, positive youth development by offering adolescents "a sense of future." The health care system was not viewed as "adolescent friendly" and seen as ill equipped to address growing mental health, psycho-social and emotional problems of teens. Hence, adolescent health promotion was chosen as a priority to highlight the unique needs and issues that affect this often overlooked segment of the MCH population within the public health system.

Data on the health and mental health of Maryland adolescents, beyond traditional vital statistics measures, is limited. The Title V Program has chosen the high school graduation rate as the state performance measure and the adolescent/young adult mortality rate as an outcome measure for this priority. Other national Title V measures linked to this priority include rates of teen births, suicide, juvenile arrests and high school drop-outs.

6. To promote healthy nutrition and physical activity across the lifespan.

Adult and childhood overweight/obesity is increasing at alarming rates in the U.S. and we suspect in Maryland. Data on the prevalence and incidence of childhood overweight is currently limited, but efforts are underway to improve obesity surveillance in Maryland. The latest BRFSS data for adults indicates that almost half were overweight or obese and that these rates have increased over the past decades. Rising rates of childhood overweight and obesity were repeatedly identified as a concern by focus group participants, service providers and local health department staff. Two major factors accounting for the rise obesity rates include unhealthy eating habits and physical inactivity. Parents in our focus groups expressed concerns about school vending machines that promote unhealthy eating habits, a decline in physical education programs and outdoor recess time in schools, and an increased reliance on sedentary activities such as television viewing and computers for entertainment. Because Maryland currently does not have an obesity/overweight surveillance system for the entire child population, a performance measure will be developed in the interim years as data capabilities in this area improve.

Breastfeeding is recognized as the optimum form of nutrition for infants throughout the first year of life. While breastfeeding initiation rates in Maryland have been improving and are approaching the Healthy People 2010 goal of 75%, few Maryland moms continue to breastfeed beyond the early months. Survey data for 2003 estimate that at six months, two in five mothers continued to breastfeed and less than one in five breastfed exclusively. Because breastfeeding has long term benefits and is viewed as essential to giving infants an optimal nutritional start in life, Maryland has chosen the percentage of infants breastfed at six months as the state performance

measure.

7. To improve systems of care for Children with Special Health Care Needs

A problem highlighted in the needs assessment by both families and providers is the issue of "navigating the system" or finding out about available services within the community and gaining access to them. This is particularly troublesome for CSHCN and their families who require not only extensive health care services but also multiple family support services. The OGCSHCN has addressed this by funding information and referral mechanisms at the large specialty centers, at a Regional Resource Center on the Eastern Shore, and at Parents' Place of Maryland. However, the majority of these centers are located centrally within the state, and getting the word out has been slow. Not all local jurisdictions are equipped to assist families with locating needed services, and parents do not feel that that pediatrician's offices are a good source of information on accessing community resources. Pediatricians agree that they don't typically have this type of information. There is a need to improve the capacity of local jurisdictions and a child's medical home to quickly and efficiently disseminate information about community resources and to advertise the information and referral mechanisms that already exist. The selected state performance measure for this priority is the percentage of jurisdictions that partner with medical homes to develop and disseminate resource materials.

8. Improve the infrastructure for supporting systems of care for women, children and families

This broad priority focuses on infrastructure level issues, namely data, work force and manpower maldistribution issues that impact the state's ability to serve mothers and children. The CAST- 5 process noted that Maryland's Title V Program has recently made substantial process in collecting and analyzing data since the last needs assessment. CMCH now employs both a senior level MCH epidemiologist and a family planning program epidemiologist. The PRAMS and YRBS datasets are now available. However, it was noted that current capacity remains insufficient for undertaking in-depth studies that could provide greater direction for development of MCH policies and interventions. For example, in the mid-nineties, Maryland had one of the nation's highest early prenatal care rates, but over the past several years, early prenatal care rates have declined significantly. The Program lacks sufficient capacity to fully examine the reasons for this decline. In this instance, staff had the expertise, but lacked the time to perform this in-depth analysis.

The CAST-5 discussions also revealed that the CMCH process for data analysis is not systematic and that greater understanding of the needs affecting the most vulnerable MCH populations in our state is the goal, then the environment for data sharing will need to be improved, in addition to work force development. The Title V Program plans to address these issues by identifying at least one major issue requiring in-depth study and analysis each program year. This work will be accomplished in partnership with other MCH serving agencies, where appropriate. The initial state performance measure for this priority will be the number of policy briefs developed.

Public health workforce and health manpower shortage and development issues were identified as a subset of this priority. A great deal of concern was expressed throughout the CAST-5 deliberations and in meetings with local health departments about the long term implications of the aging of the MCH workforce.

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	95	95	95	95	95
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	154	132	125	170	182
Denominator	154	132	125	170	182
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	95	95	95	98	98

### Notes - 2007

Newborn screening data is reported by calendar year, CY 2007, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

A new performance objective is not formulated for the coming year. Problems in obtaining data from the commercial laboratory, insufficient IT resources and the loss of veteran follow up staff have made it almost impossible to compile accurate unduplicated data. The commercial lab does not report all abnormalities, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they do not always report abnormalities, even presumptive positives on home births or babies born to Maryland residents in DC who have their initial screen in DC but their subsequent screen in Maryland, or babies born in Maryland but then transferred to the NICU at Children's National Medical Center in Washington, DC. (Maryland has a 2 specimen system.)

The number of presumptive positives has decreased. New automated pipetting systems for the assays for T4, TSH, galactosemia and biotinidase have reduced false positives. In addition, growing expertise with tandem mass spectrometry is reducing the false positives in the amino acid and acylcarnitine profiles. Our increasing expertise is due, in part, to courses taken by lab personnel at Duke and Mayo, to an ongoing relationship with Mayo and the "scorecard" project. Other factors include the constant refinement of cut offs, a lab subcommittee of our Advisory Council and the use of new ratios to evaluate abnormal patterns.

New legislation restoring a single newborn screening laboratory will take effect January 2009 and the newborn screening program will be reorganized. These changes make us confident that we can meet higher standards and have better data. Therefore a new objective is chosen for 2010.

### Notes - 2006

Newborn screening data is reported by calendar year, CY 2006, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

A new performance objective is not formulated. We are not sure if we can sustain our historical strength in this area, in part because of the problems of obtaining data from the commercial laboratory and in part because of the loss of veteran follow up staff. The commercial lab does not report all abnormalities, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they do not always report abnormalities, even presumptive positives on home births or babies born to Maryland residents in DC who have their initial screen in DC but their subsequent screen in Maryland. (Maryland has a 2 specimen system.) However, we have made progress and now receive

presumptive positives on military babies. The number of presumptive positives has not grown dramatically despite the addition of cystic fibrosis to the screening panel. New assays for T4 and TSH have reduced false positives. In addition, growing expertise with tandem mass spectrometry is reducing the false positives in the amino acid and acylcarnitine profiles.

#### **Notes - 2005**

Newborn screening data is reported by calendar year, CY 2005, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

A new performance objective is not formulated. We are not sure if we can sustain our historical strength in this area primarily because of the problems of obtaining data from the commercial laboratory. They do not report all abnormalities, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they do not always report abnormalities, even presumptive positives on home births or military babies. We continue to work with them but turn over of personnel and lack of a clinician involved in the newborn screening section of the commercial lab makes it increasingly difficult. We are concerned that the chance for us to miss a baby or lose one between the cracks has increased.

#### **a. Last Year's Accomplishments**

Newborn screening (NBS) data is reported by calendar year, CY 2007, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

Maryland screens for all the disorders recommended by the ACMG, the AAP and the March of Dimes including the secondary targets.

The program continued to struggle with the challenge of operating with 2 competing NBS labs. Problems in obtaining data from the commercial lab, insufficient IT resources and the loss of veteran follow up staff made it almost impossible to compile accurate unduplicated data. (The commercial lab does not report all abnormalities, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they do not always report abnormalities, even presumptive positives on home births or babies born to Maryland residents in DC who have their initial screen in DC but their subsequent screen in Maryland, or babies born in Maryland but then transferred to the NICU at Children's National Medical Center in Washington, DC. (Maryland has a 2 specimen system.))

In addition, it became increasingly clear that the NBS program could not meet its goals in its present form. The NBS follow up program continued to struggle with its obsolete database and with a severe manpower shortage. (The veteran NBS follow up nurse retired for health reasons and the genetic counselor obtained through the Division of Human Genetics, University of Maryland relocated for family reasons.) Significant budget cuts not only threatened the program's ability to replace key staff, but also impacted the State lab's ability to replace aging equipment and made it impossible to replace the database or obtain sufficient IT assistance. A proposal to reorganize the newborn program was formalized and approved by the OGCSHCN, the Laboratories Administration and the Secretary of the Department of Health and Mental Hygiene (DHMH).

Under the new plan, the follow up portion of the newborn screening program and the laboratory portion would be merged under the auspices of the Laboratories Administration. This would streamline administrative functions and simplify procurement of expert medical, lab and IT personnel. A new follow up module was added to the lab's contract with StarLIMS for a new NBS laboratory information system. The NBS program would become fiscally self supporting through an increase in the NBS fee, which would include a fee for follow up services. The existence of 2 competing labs would make it impossible to raise the fee. Legislation restricting 1st tier NBS to the State lab would restore a single NBS lab, simplifying follow up, data collection and allow the program to become self supporting. New legislation was drafted.

The OGSHCN continued to work with the State genetics centers to provide diagnostic evaluations. In FY 2007, the OGSHCN provided long-term follow-up services including case management, nutritional management, counseling, health education, and family support to 339 families with confirmed metabolic disorders and 1,694 children with sickle cell disease and the genetics centers served over 7,008 individuals and provided 12,746 laboratory services.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support newborn screening for all the disorders recommended by the March of Dimes, the AAP and the ACMG for all Maryland babies	X		X	
2. Reorganize the newborn screening follow up program to provide adequate trained follow up personnel			X	X
3. Work with the Laboratories Administration to construct a follow up module to the StarLims laboratory data management system.			X	X
4. Continue to refine lab testing and follow up protocols.	X	X	X	X
5. Provide short term follow up assuring that all abnormal or inadequate test results are followed to resolution	X	X	X	
6. Support the State's designated metabolic, endocrine, hematology and CF centers through small grants		X		X
7. Provide metabolic nutritionists from the OGSHCN to provide case management and nutritional therapy	X	X		
8. Provide case management for sickle cell disease patients through age 5 and continue to develop resources for transition and care for them as adults	X	X		X
9. Continue to work with the commercial laboratory to assure a smooth transition, provide 2nd tier tests and improve completeness of State data.			X	X
10. Continue to educate providers and parents, update educational materials and enhance the website.	X	X	X	X

#### **b. Current Activities**

The legislation to restore a single State NBS lab was introduced. The commercial laboratory and hospitals against the fee increase opposed. A group objecting to the long standing policy of informed consent for NBS also opposed the bill, considering refusing NBS to be child abuse and advocating the Nebraska model, which legally prosecutes parents who refuse. The bill was only intended to restrict NBS lab screening to a single lab, not to change any other policy. Under existing law, authority to change policy belongs to the Advisory Council on Hereditary and Congenital Disorders (consumer dominated with expert medical, DHMH and legislative representation.) Uncodified language requiring the DHMH to prepare a report on the issue of informed consent for NBS was added and the House Committee proposed to study all instances calling for parental consent in Maryland law and correct anything inappropriate in an omnibus bill next year, but the group still opposed. Their article, in the Baltimore Sun, focused on the program's inability, caused by having 2 labs, to produce clearly unduplicated NBS data to argue that thousands of babies go unscreened and to question the competence of the program. (Actually, 3 families refused in 2007.) The Secretary, the AAP, the State medical society, tertiary care centers, pediatricians, obstetricians, hospitals and parent groups replied, putting the issue in perspective and praising the program's services and accomplishments. The legislation was passed.

### c. Plan for the Coming Year

The legislation to restore a single NBS lab takes effect January 1, 2008. The reorganization plan will be implemented. Regulations proposed prior to the new legislation will be revised and promulgated.

The Advisory Council had its 1st meeting devoted to informed consent, including testimony from Dr. Tony Holtzman, the originator of the policy and the leading national proponent of informed consent for NBS. Work to produce the report will be ongoing.

A new NBS follow up nurse was recruited in December of 2007 and a new genetic counselor in June 2008. Both are being trained. Job descriptions for additional NBS follow up staff and the dedicated IT staff person are being drafted. New staff will be recruited and trained.

The NBS Practitioner's Manual will be updated, distributed and posted on the website. Educational materials and the website will be refined.

The NBS staff will continue to work with the IT staff from the Family Health Administration, the Laboratories Administration and the StarLims systems design personnel/ programmers to develop the new follow up module. The lab module will go live in August. The NBS follow up staff will be trained in its use. Primary care providers and tertiary care centers will be trained to obtain results and to add follow up information to the follow up module.

The program continues to refine its lab testing protocols and replace ageing equipment. Considerable progress on reducing false positives has been made. New automated pipetting systems for the assays for T4, TSH, galactosemia and biotinidase have reduced false positives. Growing expertise with tandem mass spectrometry is reducing false positives in the amino acid and acylcarnitine profiles. Our increasing expertise is due to experience, lab courses at Duke / Mayo, an ongoing relationship with Mayo, the "scorecard" project, the constant refinement of cut offs, a lab subcommittee of our Advisory Council and the use of new ratios to evaluate abnormal patterns.

Fewer false positives and the restoration of a single lab make us confident that we can meet higher standards and have better data, so a new objective is chosen for 2010.

The program will continue to work with Dr Ann Moser on the NBS test for X-linked Adrenal Leukodystrophy and with Dr Jennifer Puck on the protocol for Severe Combined Immune Deficiency. The program will continue with the CDC/HRSA project to evaluate the usefulness of the routine second newborn screening specimen for endocrine disorders. The program will also work with researchers to study family experiences with false positives, to improve our interaction with families to minimize the negative effects of false positives, to study the optimal method of informing families about carrier status, to study long term outcomes in patients identified with SCD and other disorders, and to study the possible role of NBS in identifying both mothers and babies with disturbed B12 utilization at risk for hematological problems.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	70	70	70	71	72
Annual Indicator	68.1	68.1	68.1	68.1	54.8

Numerator	142329	142329	142329	142329	
Denominator	209000	209000	209000	209000	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	55	55.5	56	56.5	57

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual Performance Objectives have been revised based on the most recent data.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

#### a. Last Year's Accomplishments

According to the 2005-06 National Survey of CSHCN (NS-CSHCN), just under 55% of Maryland families of CYSHCN report that they are partners in decision-making and are satisfied with the services they receive, compared with over 57% nationally. This is a significant change from the 2001 NS-CSHCN, when over 68% of families of CYSHCN reported success in this outcome. This is a disappointing finding, as family-professional partnership and satisfaction with care have traditionally been areas of relative strength for Maryland compared with other states. The reasons for this change are not clear.

The OGCSHCN continued its support of The Parents' Place of Maryland (PPMD), a non-profit, family-directed and staffed center serving parents of children with disabilities and special health care needs. PPMD also houses the Maryland Chapter of Family Voices. PPMD and OGCSHCN have an ongoing partnership in a number of activities, including the Family-to-Family Health Education and Information Center, which serves as a statewide resource about the health care system by providing information, support, advocacy, and referrals for families of CYSHCN. In FY07, PPMD parent staff provided individual assistance to over 500 parents of CYSHCN through telephone, e-mail, and face-to-face meetings. PPMD has been very successful in its minority outreach efforts; 42% of those served were minority parents. PPMD has fostered relationships with a number of organizations connected with ethnic/racial minority populations and is able to provide materials and training in Spanish and uses community contacts for translation in other languages. PPMD also sends out a monthly newsletter (ParenTalk) covering both health and education topics that reached at least 13,200 individuals.

Last year, PPMD conducted a variety of workshops for both parents and professionals aimed at increasing partnership and advocacy skills and effectively accessing health care services for CYSHCN. In FY07, PPMD conducted 45 workshops across the state for 815 parents and 394 providers. PPMD also held two intensive, two-day trainings entitled, "Maryland Health TIES" to support and assist parents to improve their capacity to partner with policymakers to help systems

of care be more responsive to the needs of families of CYSHCN. A total of 28 parents participated in these trainings, one in Western Maryland on one on the Eastern Shore. PPMD continues to provide information and support to these parents as they go on participate in local committees and workgroups.

OGCSHCN support enables PPMD staff to participate in a number of venues, providing parent input into health policy and program design activities. For instance, a PPMD parent representative spends one day per week in the State Medicaid office, and also sits on the Medicaid Advisory Committee. Parents provide representation on the State Rehabilitation Advisory Board, State Interagency Coordinating Council, Autism Waiver Steering Committee, and a number of local committees. PPMD also chairs the Medical Home Leadership Team with the OGCSHCN.

OGCSHCN itself employs two parents of CSHCN. One heads the Birth Defects Reporting and Information System and provides information and referrals to the parents of infants with birth defects. The second is our Regional Resource Development Coordinator. She is particularly active and effective in lending her expertise as a parent to the Maryland Developmental Disabilities Council, The Maryland Caregiver's Support Coordinating Council, and the Maryland State Department of Education's Inclusive Child Care Work Group, among other activities.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support The Parents' Place of Maryland to provide families of CYSHCN with a central source of information, education, direct family support and referrals		X		X
2. Support The Parents' Place of Maryland to provide parent training, including Health TIES (Training, Information, Education, and Support) program		X		X
3. Support parent input into health policy and program design activities				X
4. Support employment of family members of CYSHCN		X		X
5. Collaborate with partners to collect data and information from families of CYSHCN via multiple sources				X
6. Support The Parents' Place of Maryland to implement a Families as Faculty Program				X
7. Work with The Parents' Place of Maryland and other stakeholders to develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports family-professional partnerships				X
8.				
9.				
10.				

#### **b. Current Activities**

The OGCSHCN continues to gather data and information from families of CYSHCN to assess their needs and ensure that families have a voice in program and policy decisions to the extent possible. OGCSHCN is currently completing the data analysis from a needs assessment in one local jurisdiction. Data is also collected from parents who contact PPMD for assistance; this data documents the issues, concerns, and gaps in services they identify. The OGCSHCN also continued to work with PPMD to enroll families of CYSHCN in a voluntary, confidential database to be use for ongoing needs assessment purposes.

PPMD is implementing a Family Faculty program this year. PPMD identified appropriate staff to coordinate the program; researched several other Family Faculty programs around the country; and contacted local educational and training programs for medical students, pediatric residents, and other professionals. With support from OGCSHCN, almost 50 diverse parents were recruited and received training. During the current year, the University of Maryland is participating, and pediatric residents in their developmental and behavioral rotation are being matched with families for a home visit followed by a debriefing. The Johns Hopkins School of Public Health requested that students in its annual CSHCN seminar participate; this was also accomplished this year. Evaluations have been positive, and PPMD is in discussion with other institutions regarding starting programs for their trainees.

### c. Plan for the Coming Year

The ongoing activities described above will continue in the coming year. In addition, PPMD, in partnership with the OGCSHCN, has been awarded a State Implementation Grant for Integrated Community Systems for CYSHCN from MCHB. Block grant funded staff from the OGCSHCN are providing critical leadership and staff support to this Project. Under the Project, a Community of Care (COC) for CYSHCN Consortium will be developed. The COC Consortium will provide the leadership and infrastructure for the Project; members will engage in collaborative planning, implementing, and evaluating strategies to achieve and sustain an integrated, community-based system of services for CYSHCN and their families. Support of family-professional partnerships and cultural competency will be integral to the activities of COC Consortium. A diverse group of stakeholders (racially, ethnically, culturally, linguistically, socioeconomically, and geographically), including parents and other family members of CYSHCN, will be recruited for participation in the Consortium and each of its work groups. The Consortium and its work groups will be charged with identifying and implementing strategies to promote family-professional partnerships and cultural competency within all of their activities. Examples include incorporating principles of family-professional partnership and cultural competency into their mission, goals, and operating procedures; considering and addressing known disparities when prioritizing and implementing strategies; gathering data from diverse groups; and requiring that mini-grantees (grants to be awarded for community implementation during the Project) include family participation and strategies to address cultural competency within their implementation projects.

In addition, family members will be required participants in other planned activities under the Project, including serving as key members of community teams for Community of Care for CYSHCN Learning Collaboratives and participating in activities related to improvements in developmental screening and follow-up. New family members in all activities will be paired with experienced parent professionals (PPMD regional parent coordinators) for mentorship and support. PPMD parent coordinators will assess the information and training needs of their designated family members and provide individual or group training tailored to these needs, or invite them to participate in relevant ongoing leadership training and activities conducted by PPMD's Family-to-Family Health Education and Information Center. Family members will receive stipends for their participation and expertise, as well as reimbursement for travel and childcare. The Consortium will strive to accommodate the special needs of any of its members including sign and foreign language interpretation. Both OGCSHCN and PPMD now have a Spanish-speaking staff person who will be able to provide interpretation and translation of written materials as needed.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	60	60	60	61	62

Annual Indicator	56.3	56.3	56.3	56.3	45.6
Numerator	117667	117667	117667	117667	
Denominator	209000	209000	209000	209000	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	46	46.5	47	47.5	48

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

#### a. Last Year's Accomplishments

While having a medical home is important for all children, CYSHCN in particular need the type of care embodied by this model. According to the 2005-06 NS-CSHCN, 45.6% of Maryland CYSHCN are receiving care that meets criteria for a medical home compared with 47.1% nationally. Although there were significant differences in the way medical home was measured between the 2001 and 2005-06 surveys, Maryland dropped in its successful achievement of this outcome from 10th in the nation to 38th.

The Office for Genetics and Children with Special Health Care Needs (OGCSHCN) has continued to work with children and families who are identified and receive services through its programs to find a medical home to the extent possible, including those identified through the metabolic and hearing screening programs and the birth defects program, and those served in the Children's Medical Services specialty care payment program. In addition, OGCSHCN continued to support the Complex Care Program at Children's National Medical Center. This program supports medical homes by bridging and filling the gap between primary care providers and tertiary services provided by the medical center. Both clinical and care coordination services are offered. This program continues to grow, and in FY07 there were 292 visits for 153 patients, of which 76 were new to the program.

Last year, the OGCSHCN hired a Medical Home Projects Coordinator to provide support to the Medical Home Leadership Team (MHLT) and coordinate implementation of the medical home state plan for CYSHCN and related projects. The MHLT continued to meet regularly and had a number of accomplishments. One of these was the completion and dissemination of adapted versions of the New England SERVE medical home brochures for providers and parents for use in Maryland. In addition, the MHLT piloted an educational program targeted at a small group of pediatricians and key office called "Extreme Medical Home Makeover." This was a series of four interactive learning and sharing sessions over a several month period aimed at providing participants with concrete tools and strategies to enhance the provision of high quality primary

care for CYSHCN. Participants had the opportunity to hear from experts and engage with peers in a small group format. Session topics included coding and reimbursement for complex patients; care coordination and chronic condition management; understanding and finding community resources; and quality improvement strategies. A total of eight primary care practices participated; however, attendance dropped off significantly as the sessions went on. The MHLT will be considering whether adaptations to the model might improve practice retention in addition to exploring other creative pediatric primary care practice education models.

Identifying and making needed improvements in the system of care coordination for CYSHCN through local health departments has continued to be a priority for the OGCSHCN. The Coordinating Center, Inc. has been working with the OGCSHCN and local health department staff to address some previously identified areas of need, including the development of a process and tools to improve consistency in the practice of care coordination across jurisdictions, as well as a reporting system to capture activities related to care coordination for the purpose of evaluation, accountability, and quality improvement. Unfortunately, due to continued level funding through the Block Grant, the capacity of the local health departments to provide care coordination for CYSHCN is shrinking. The OGCSHCN has been considering ways in which to maximize current resources as well as obtain additional sources of funding for care coordination. To date, two over-the-market requests for state general funds to study a regional model of public health care coordination through the local health departments have not been approved, however.

The Baltimore City Health Department (BCHD), with support from OGCSHN, has continued its "Medical Homes Project" aimed at improving the quality of medical homes for children in Baltimore City. This project is actively working towards improving the rates with which pediatric primary care providers in Baltimore City effectively screen young children for developmental delays as well as strengthening linkages between pediatric primary care providers and BCHD resources that can support the health and development of young children at risk.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with families receiving services through the OGCSHCN to find medical homes		X		
2. Support the Complex Care Program at Children's National Medical Center		X		X
3. Provide leadership and support for Maryland's Medical Home Leadership Team and medical home state plan				X
4. Educate families and providers about medical home partnerships through dissemination of materials and conducting trainings and presentations			X	X
5. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to system		X		X
6. Support multiple efforts to improve developmental screening and appropriate referral for all children within the medical home through policy-level and practice-level change			X	X
7. Work with The Parents' Place of Maryland and other stakeholders to develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports medical home improvement				X
8. Plan and begin implementing a Community of Care for CYSHCN Learning Collaborative				X
9. Support Johns Hopkins University in the development of a medical home model for selected high prevalence, high impact				X

and/or high cost conditions within the Harriet Lane Clinic				
10.				

#### **b. Current Activities**

Maryland was one of the twenty states selected to participate in the Assuring Better Child Health and Development (ABCD) Screening Academy; Maryland Medicaid/EPSTD, the OGCSHCN, and the Maryland Chapter of the American Academy of Pediatrics (AAP) are partnering in this effort, aimed at identifying and implementing state policy and systems level changes needed to improve developmental screening within the medical home. A Developmental Screening Advisory Group comprised of key stakeholders and several work groups have been formed. Three pilot pediatric practices were trained and are currently implementing standardized general developmental screening tools at 9-, 18-, and 24-month well child visits. Mid-project screening rates, available for two of the practices, increased from a baseline of 0% screened to 60% and 82% of screen-eligible children receiving screening with a standardized tool. In addition, the Healthy Kids (EPSTD) provider manual is being updated to reflect the screening recommendations of the AAP; lists of approved and recommended general developmental screening tools have been selected for the Healthy Kids Program; Maryland Medicaid will be making changes to allow up to two units of CPT 96110 on the same date of service; and a universal referral and feedback form has been developed with the Maryland Infants and Toddlers Program and is being piloted. There has been quite a bit of enthusiasm generated around this project from multiple partners.

#### **c. Plan for the Coming Year**

The ongoing activities described above will continue in the coming year. In addition, The Parents' Place of Maryland (PPMD), in partnership with the OGCSHCN, has been awarded a State Implementation Grant for Integrated Community Systems for CYSHCN from the Maternal and Child Health Bureau. Block grant funded staff from the OGCSHCN are providing critical leadership and staff support to this Project. In the coming year, a Community of Care (COC) for CYSHCN Consortium will be developed; the existing Medical Home Leadership Team and Developmental Screening Advisory Group will be transitioned into work groups of the COC Consortium to sustain their current activities and support additional Project goals and objectives.

One of the Project's major goals is to improve access to family-centered, coordinated, comprehensive care for CYSHCN through medical homes that are part of an integrated, community-based system of services. A key strategy is to use the learning collaborative approach, based on the general structure of the NICHQ Medical Home Learning Collaboratives, as a mechanism for achieving medical home improvement. A unique feature within in this Project will be a community-level focus to the design and implementation of the learning collaboratives. In the coming year, the Medical Home Work Group of the COC Consortium will assist with curriculum development and selection of community teams to participate in a Community of Care for CYSHCN Learning Collaborative.

Another Project goal is to improve developmental screening in young children and linkage with appropriate community-based services. The Maryland AAP will be implementing a train-the-trainer model to spread developmental screening training to medical homes statewide. In the coming year, this process will be initiated with assistance from the Early and Continuous Screening Work Group of the COC Consortium. The trainings will be conducted by physician trainers and Maryland Healthy Kids (EPSTD) staff as well as local representatives from the Maryland Infants and Toddler Program and local PPMD parent representatives. This will provide the opportunity for pediatric primary care providers and their staff to network with these local resources, and learn more about their services and how to access them for families.

Lastly, Johns Hopkins University, supported by OGCSHCN, has revamped its grant work plan for FY09 and will attempt to develop a sustainable medical home model, focusing first on high prevalence, high impact and/or high cost conditions including asthma, ADHD, and sickle cell disease. This model will be developed and evaluated in the Harriet Lane Clinic and will involve: 1)

case management; 2) feedback to providers about medication refills and health care utilization based on insurer data; 3) enhanced specialist-generalist communication; 4) targeted interventions with high-utilizing children and 5) improved services to facilitate transition of YSHCN to adult health care providers.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	70	70	70	70	70.5
Annual Indicator	67.5	67.5	67.5	67.5	65.5
Numerator	141075	141075	141075	141075	
Denominator	209000	209000	209000	209000	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	65.7	65.9	66.1	66.3	66.5

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual Performance Objectives have been revised based on the most recent data.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be our best estimate of this performance measure.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

#### a. Last Year's Accomplishments

On the 2005-06 National Survey of CSHCN (NS-CSHCN), 97% of Maryland families of CYSHCN reported that their child had public or private health insurance at the time of the interview, similar to findings from 2001. Adequacy of health insurance is a greater challenge; based on the 2005-06 NS-CSHCN, over 1/3 of Maryland CYSHCN do not have insurance that is adequate to pay for the services they need. There was a slight decrease in performance on this measure since 2001, and Maryland's ranking among the states dropped from 5th to 14th.

In the past year, the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) continued to partner with The Parents' Place of Maryland (PPMD) in its Family-to-Family Health Information and Education Center. One of the goals of this center is to increase the knowledge and skills of parents/caregivers of CYSHCN so that they may more effectively access health care services for their children. PPMD has developed and has been continuously refining

health-related workshops for families, several of which are related to insurance issues including, "Choosing a Health Care Plan," "Getting Needed Services from Your Health Plan," "Appealing Health Plan Decisions," and "Understanding Medical Assistance in Maryland." These workshops are scheduled on an ongoing basis throughout the state, both face-to-face and by teleconference. In FY07, PPMD staff conducted 45 workshops across the state with a total of 1209 participants (815 parents, 394 providers). PPMD parent staff members are also available to provide individual assistance to parents of CYSHCN through telephone, e-mail, and face-to-face meetings. In FY07, individual contact was provided to 503 parents. Tracking this contact data, four out of the five most common parent concerns were related to access to appropriate providers, access to or funding for services, and plan benefits.

OGCSHCN also continued to support opportunities for PPMD staff to provide parent input into insurance-related policy and program design activities. For instance, a PPMD family representative spent one day per week in the central Medicaid office, and participated on the Medicaid Advisory Committee. In addition, PPMD parent staff met with the Special Needs Coordinators from each HealthChoice MCO to share information and resources regarding CYSHCN, and disseminated information about CYSHCN to REM case managers on a regular basis.

The OGCSHCN continued to provide payment for specialty care and related services through the Children's Medical Services Program (CMS) to Maryland CYSHCN who are uninsured or underinsured and have family incomes up to 200% FPL. The OGCSHCN was recently successful in passing changes to CMS regulations that allow the Program's income eligibility guidelines to automatically update each year in accordance with the new federal poverty guidelines, which should improve eligibility for the Program. In FY07, CMS paid for services for approximately 200 CYSHCN. The vast majority of the children served by the program are Hispanic immigrants. The Program's bilingual outreach coordinator works with families and providers to facilitate access to timely and appropriate CMS Program services. The capability of directly providing Spanish-language services to CMS families has been invaluable to the Program. CMS also recently welcomed a new bilingual care coordinator based in Montgomery County where the majority of CMS eligible children and families reside.

The OGCSHCN continued to refer potentially eligible families to Medicaid programs as well as other public programs that might provide pathways to securing funding for health care and related services such as SSI and the Developmental Disabilities Administration. For those who are not eligible for these programs nor CMS, the office makes every effort to connect the family with other charitable sources of care and resources, such as Catholic Charities.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support The Parents' Place of Maryland to educate parents of CYSHCN about health insurance and how to access services for their children through a series of workshops		X		X
2. Support parent input into policy and program design activities related to health insurance for CYSHCN				X
3. Provide payment for specialty care and related services for CYSHCN who are uninsured or underinsured with family incomes up to 200% FPL through the Children's Medical Services Program	X			
4. Implement changes to Children's Medical Services program regulations that will allow the program to serve more CYSHCN				X
5. Provide outreach and case management to Hispanic families through bilingual staff in Children's Medical Services program		X	X	

6. Disseminate "Families Report on the State of the State" report that addresses a variety of financing and insurance issues				X
7. Partner with Medicaid and private insurers to implement policy changes that support improvements in developmental screening, including coding and reimbursement				X
8. Work with The Parents' Place of Maryland and other stakeholders to develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports adequate insurance				X
9. Conduct a cost-benefit analysis of Maryland's two medical day care centers for infants and young children				X
10.				

#### **b. Current Activities**

A report entitled, "Families Report on the State of the State" has been developed by the Maryland Family Access Initiative, a collaborative project between PPMD and the Georgetown University Center for Child and Human Development and funded by the Maternal and Child Health Bureau (MCHB). This report presents data from several sources, including a family survey supported by OGCSHCN. The report highlights what families and providers have to say about the challenges faced by families of CYSHCN with emphasis on a variety of financing and insurance issues. The report includes a call to action with specific recommendations and is being widely disseminated throughout the state.

The OGCSHCN, Maryland Medicaid/EPSTD, and the Maryland Chapter of the American Academy of Pediatrics (AAP) continue to partner in the Assuring Better Child Health and Development (ABCD) Screening Academy. This project has engaged both Medicaid MCOs and private insurers to address financing issues related to the use of standardized developmental screening tools and other components of developmental evaluation. Maryland EPSTD has updated its periodicity schedule and provider manual to reflect the recommendations of the AAP for general developmental screening, and as of July 1, 2008 Maryland Medicaid will allow up to a maximum of 2 units of CPT 96110 on the same date of service, and reimbursement for CPT 96111 will increase significantly.

#### **c. Plan for the Coming Year**

The ongoing activities described above will continue in the coming year. In addition, PPMD, in partnership with the OGCSHCN, has been awarded a State Implementation Grant for Integrated Community Systems for CYSHCN from MCHB. Block grant funded staff from the OGCSHCN are providing critical leadership and staff support to this Project. Under the Project, a Community of Care (COC) for CYSHCN Consortium will be created. This group, comprised of broad group of stakeholders, is a critical component of the leadership and infrastructure needed for achieving integrated, community-based systems of care in Maryland. One of the first tasks of the COC Consortium will be to come together in a Community of Care for CYSHCN Summit to assist with the development of a statewide strategic plan addressing all of the core outcomes, including adequate insurance. Both Medicaid and Medicaid MCOs have already agreed to participate in this process. Further, issues of financing and insurance will be woven into all of the planned activities of the Project including medical home improvement, developmental screening, and youth involvement/health care transition.

Lastly, due to continued level funding through the Block Grant, Maryland's two medical day care centers have expressed concerns about their ability to maintain their current capacity and services. The centers have been involved with both legislative and other advocacy efforts in an attempt to increase state funding for these centers through other sources such as increased Medicaid reimbursement and new general funds. While these efforts have had some success, fiscal concerns remain. The OGCSHCN has initiated a Memorandum of Understanding with the

Maryland Institute of Policy Analysis and Research at the University of Maryland, Baltimore County to conduct a cost-benefit analysis of medical day care in Maryland. This type of analysis has never been done for these centers. The goal is to obtain data that can be used to evaluate the current medical day care model from a fiscal standpoint and assist with future planning and advocacy efforts to ensure the continued availability of this service in Maryland.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	75	75	75	75	75.5
Annual Indicator	70.6	70.6	70.6	70.6	89.3
Numerator	147554	147554	147554	147554	
Denominator	209000	209000	209000	209000	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	89.5	89.7	89.9	90.1	90.3

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Annual Performance Objectives have been revised based on the most recent data.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be our best estimate of this performance measure.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

#### a. Last Year's Accomplishments

On the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN), over 89% of Maryland families reported no difficulty using any of the health-related services needed by their child in the previous year, ranking 26th among the states. Performance on this measure was significantly better than in 2001 (70.6%, 42nd in nation); however, there were major differences in the methods by which this data was derived between the survey years. While the majority of families of CYSHCN responded favorably, approximately one in ten families still report difficulty using needed services. Based on the NS-CSHCN and other data sources, we know that racial, ethnic, cultural, linguistic, socioeconomic, and geographic disparities exist in relation to ease of community-based service use.

The Office for Genetics and Children with Special Needs (OGCSGCN) has long worked to improve the availability of and access to needed health and family support services for CYSHCN in Maryland. Over the past year, the OGCSGCN continued to support selected outreach specialty clinics throughout the state, including genetics, developmental pediatrics, and endocrinology clinics. However, it is becoming increasingly difficult to maintain the infrastructure for these clinics. Both the continued availability of funding as well as the sub-specialty manpower to staff the clinics are areas of concern. In FY07, there were over 1250 visits made to 19 outreach specialty clinics serving Maryland CYSHCN and supported by OGCSHCN.

The OGCSHCN has also continued its efforts to address the need for assistance with "navigating the system" i.e. finding and accessing available resources within the community. The OGCSHCN awards grant to four Centers of Excellence in Maryland and Washington, D.C. to support a Resource Liaison or similar personnel at each center whose function is to assist families of CYSHCN to find needed resources both within the centers and within the community. In some centers, these individuals may work directly with particular clinics and play a greater role in coordinating the care of CYSHCN; for instance, the ASK Program (Access for Special Kids) at the University of Maryland places one nurse in the pediatric primary care clinic, and one nurse in the specialty clinics to assist families with finding resources and coordinating care. The Centers of Excellence are an obvious place to target CYSHCN and their families; in FY07, there were over 100,000 visits made to specialty clinics at the 3 largest centers.

In addition, grants from the OGCSHCN continued to fund gap-filling care coordination for CYSHCN in a number of jurisdictions (just over 1000 children served in FY07), and operation of the Regional Resource Center for Children with Special Needs in Wicomico County on Maryland's Eastern Shore. This center, located in the Wicomico County Free Library, staffs a Resource Coordinator for information and referral. It houses accessible computers for child and family use as well as books and audio/videotapes on a variety of special needs topics. OGCSHCN also continued to provide funding to the Parents' Place of Maryland (PPMD) to expand its Family-to-Family Health Information and Education Center, which operates a toll-free information and referral line as well as a network of parent representatives throughout the state who are available to work one-on-one with families of CYSHCN.

The availability of quality childcare and respite services for CYSHCN within their communities also remains a significant problem in Maryland. OGCSHCN continued to support the operation of two medical day care centers that served 89 medically fragile infants and young children in FY07. These unique centers provide quality childcare, nursing, and developmental services to children whose medical needs are too great to be served in traditional day care settings, allowing their caregivers to return to work. Also continued were grants to local health departments for the funding of a variety of respite services for 556 children and families in FY07.

Lastly, OGCSHCN worked with the Maryland Early Intervention Program to monitor and assure the quality of Early Intervention services for families in their communities. OGCSHCN distributes the federal match for the Medicaid eligible children receiving Early Intervention case management, 4,625 children in FY07.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support selected subspecialty outreach clinics throughout the state		X		X
2. Support a Resource Liaison or similar personnel at 4 Centers of Excellence, Regional Resource Center on the Eastern Shore, and The Parents' Place of Maryland for outreach, information, and referral to families and providers		X		X

3. Support the operation of 2 medical day care centers serving medically fragile infants and young children		X		X
4. Support the local health departments and parent organizations to provide a variety of respite services to families of CYSHCN		X		
5. Work with the Maryland Early Intervention Program to monitor and assure the quality of Early Intervention services for families in their communities				X
6. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to system		X		X
7. Work with partners to develop web-based county-specific resource lists for each jurisdiction and disseminate		X		
8. Work with The Parents' Place of Maryland and other stakeholders to develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports easy to use, community-based service systems				X
9. Plan and begin implementing a Community of Care for CYSHCN Learning Collaborative				X
10.				

#### **b. Current Activities**

Identifying and making needed improvements in the system of care coordination for CYSHCN through local health departments is a current priority for the OGCSHCN. The Coordinating Center, Inc. is working with the OGCSHCN and local health department staff to address some previously identified areas of need, including the development of a process and tools to improve consistency in the practice of care coordination across jurisdictions, as well as a reporting system to capture activities related to care coordination for the purpose of evaluation, accountability, and quality improvement. Unfortunately, due to continued level funding through the Block Grant, the capacity of the local health departments to provide care coordination for CYSHCN is shrinking. The OGCSHCN is considering ways in which to maximize current resources as well as obtain additional sources of funding for care coordination. To date, two over-the-mark requests for state general funds to study a regional model of public health care coordination through the local health departments have not been approved, however.

OGCSHCN has recently completed its development of brief, county-specific resource lists for each jurisdiction that are posted on the web, linked to a map of Maryland's counties. Availability of these lists will be publicized to both providers and families through multiple mechanisms in partnership with the Maryland Chapter of the American Academy of Pediatrics, PPMD, and local health department staff.

#### **c. Plan for the Coming Year**

The ongoing activities described above will continue in the coming year. In addition, PPMD, in partnership with the OGCSHCN, has been awarded a State Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs from the Maternal and Child Health Bureau. Block grant funded staff from the OGCSHCN are providing critical leadership and staff support to this Project. Under the Project, a Community of Care (COC) for CYSHCN Consortium comprised of a diverse group of stakeholders including parents and providers, advocates and administrators, consumers and professionals from the public, private, and non-profit sector and at both the state and community levels will be developed. The COC Consortium members will engage in collaborative planning, implementing, and evaluating strategies to achieve and sustain an integrated, community-based system of services for CYSHCN and their families. Preliminary background work with the OGCSHCN and PPMD for

development of the COC Consortium has already begun, led by Deborah Allen, SC.D., Executive Director of the MA Consortium for CSHCN and supported by technical assistance from MCHB. In the coming year, the work of the COC Consortium will be "kicked off" with a Community of Care for CYSHCN Summit, where a statewide strategic plan for all of the core outcomes will be developed. The COC Consortium members will then go on to prioritize and select strategies outlined in the strategic plan, including evidence-based and best practice strategies, for implementation in communities. Community implementation will be supported in later years of the Project through a mini-grant process.

Another focus of the grant activities is medical home improvement using a learning collaborative approach. Medical homes are well-positioned to serve as a base for integrating community-based services for CYSHCN and their families; a unique feature of the approach that will be taken in the Project is a community-level focus to the design and implementation of the learning collaboratives. Community partners will be actively engaged to participate on quality improvement teams with pediatric primary care practices in order to share information/resources, to make personal contacts, and to identify and implement needed areas of quality improvement in the ways the systems of care can communicate and coordinate efforts on behalf of the children they serve.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	10	10	10	11	12
Annual Indicator	5.8	5.8	5.8	5.8	37.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	38	38.5	39	39.5	40

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Annual Performance Objectives have been revised based on the most recent data.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be our best estimate of this performance measure.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

#### **a. Last Year's Accomplishments**

New data from the 2005-06 National Survey of CSHCN estimates that only 37.4% of Maryland CYSHCN ages 12-17 receive the services necessary to make the transition to adult health care, work, and independence, compared with 41.2% nationwide. Maryland ranks 42nd among the states for success in this outcome. This is only slightly better than ranking 44th in 2001; however, there were major differences in the methodology between the two survey years.

The Office for Genetics and Children with Special Health Care Needs (OGCSHCN) continued its efforts over the past year to promote successful health care transition for youth with sickle cell disease and diabetes through support of transition clinics at the Johns Hopkins Hospital for each of these populations. The transition clinic for youth with sickle cell disease is located in the Department of Internal Medicine. Youth between the ages of 18 and 24 years are cared for jointly by the pediatric and adult hematologists for a period of time prior to transfer of care to the adult hematology clinic. In FY07, the transition clinic welcomed 14 new patients between the ages of 18 and 24 years and there were a total of 60 visits for all patients in this age group. The transition clinic for youth with diabetes targets patients in their last year of high school. In this model, parents and youth are introduced to the adult endocrinologist at the transition clinic. The adult endocrinologist meets with the patients and their parents both with and without the pediatric endocrinologist. In FY07, the clinic saw 38 patients in 11 transition clinic sessions. In addition, the diabetes transition clinic staff is collaborating with a research psychologist at NIH on an evaluation component. Enrollment is in process under the IRB-approved research protocol Transition from Pediatric to Adult Diabetes. The study has 3 parts: 1) a "pre-transition" interview looking at patient (15-17 year olds) and parent expectations for post-pediatric care; 2) a "post-transition" interview of 18-22 year old patients who graduated to adult care, and 3) a longitudinal study evaluating the transition program by looking at the same patients both before and after the transition. At the close of 2007, a total of 84 patients had been recruited for the study. In addition, 20 patients from the research protocol have transitioned from pediatric to adult endocrinology care.

The OGCSHCN continued to provide funding for Kennedy Krieger's Transition Lecture Series. This lecture series is currently completing its 5th year, and has been very successful. The series is open to youth, families, and providers, and in FY07 a total of almost 100 individuals attended seven lectures featuring topics such as, "Emergency Preparedness for Persons with Disabilities," "Special Needs Trusts," and "Home Business Opportunities." The lectures are videotaped and copies are available for families to loan and view at home. Additional copies of the videotapes are made available at the Regional Resource Center for Children with Special Needs located in Wicomico County on the Eastern Shore.

The OGCSHCN continued to partner with the Maryland State Department of Education to disseminate an educational sheet for families of CYSHCN that describes, "10 Steps to Health Care Transition" and links to state and national resources. This educational sheet is being provided on an ongoing basis to all families of children with IEPs and special health care needs in Maryland public high schools. An OGCSHCN staff person has also attended regional meetings with the middle and high school-based transition counselors this year and presented information and resources in an effort to increase their understanding of the health care transition process and how to better support youth and families. Staff from OGCSHCN and The Parents' Place of Maryland (PPMD) also conducted a number of workshops related to health care transition at the interagency Maryland Transition Conference this year.

Lastly, the OGCSHCN pays for specialty care and related services for YSHCN enrolled in the Children's Medical Services (CMS) Program until they reach the age of 22 years. Care may be covered until age 25 years in some special circumstances. The CMS Program staff work with YSHCN and their families to assist them with transitioning into programs for adults well in

advance of the time when they will lose their eligibility for the CMS Program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support transition clinic activities including clinics for youth with sickle cell disease and youth with diabetes		X		X
2. Support monthly Transition Lecture Series for youth, families, and providers hosted by Kennedy Krieger		X		
3. Partner with Maryland State Department of Education to disseminate "10 Steps to Health Care Transition" education sheet to high school students with IEPs			X	
4. Provide payment for specialty care and related services for uninsured YSHCN until age 22 years through Children's Medical Services program	X			
5. Support the work of the legislatively mandated Statewide Steering Committee on Services for Adults with Sickle Cell Disease				X
6. Educate youth, families, and providers about health care transition through presentations at multiple venues		X		X
7. Partner with The Parents' Place of Maryland to develop a Youth Advisory Council to the OGCSHCN				X
8. Partner with the Interagency Transition Council to assess programs serving transition-age youth for incorporation of health care transition elements				X
9. Support Johns Hopkins university and University of Maryland in efforts to assess and improve health care transition services				X
10.				

#### **b. Current Activities**

As legislatively mandated in HB 793, the Statewide Steering Committee on Services for Adults with Sickle Cell Disease has been established through the work of the OGCSHCN. The OGCSHCN has tried to use its involvement as a mechanism for raising awareness of health care transition issues, particularly the need to ensure that children with sickle cell disease, as well as the larger population of CYSHCN, have appropriate systems of health care to transition into as adults. The Steering Committee's responsibilities include establishing institutional and community partnerships; educating the public and health care providers; and developing a comprehensive education and treatment program for adults with sickle cell disease.

One related success story is the recent grand opening of the Sickle Cell Infusion Center at Johns Hopkins. The Infusion Center provides treatment of sickle cell disease crises in a dedicated urgent care center where each patient is known to the staff; this is more efficient than use of the emergency room and often avoids an admission to the hospital. Other services provided by the Center include a monthly support group, transition services for teenagers, outpatient sickle cell clinics, a team that evaluates all sickle cell patients admitted to the hospital, and 24/7 consultative services to doctors throughout the state.

#### **c. Plan for the Coming Year**

PPMD, in partnership with the OGCSHCN, has been awarded a State Implementation Grant for Integrated Community Systems for CYSHCN from MCHB. Block grant funded staff from the OGCSHCN are providing critical leadership and staff support to this Project. One of the Project goals is to increase focus on the unique needs of YSHCN, including health care transition, in

systems of care serving Maryland youth. This will be accomplished through a number of activities. PPMD and the OGCSHCN plan to increase the participation of youth in advisory roles within the state and community through the development of a Youth Advisory Council (YAC) to the OGCSHCN. In the coming year, transition-age youth will be recruited to participate in the YAC and provided with training, mentorship, and stipends. By the end of the coming year, each youth will be supported to identify and choose an ongoing "advisory role" based on his/her interests, skills, and abilities. These roles could include joining a project work group or other committee, presenting at a conference, reviewing materials (including the Title V block grant), mentoring other youth, etc. For each advisory role chosen, the youth will receive staff support and mentorship.

As an additional component of the Project, PPMD and the OGCSHCN plan to identify and implement strategies among providers, agencies, and organizations currently serving YSHCN to facilitate health care transition. Maryland has a legislatively mandated Interagency Transition Council whose purpose is to ensure a unified and coordinated transition service system, but health care transition has traditionally not been a strong focus. In the coming year, PPMD and OGCSHCN will work with this Council to assess its member agencies/organizations to determine which health care transition elements are incorporated into their programs and processes for transitioning youth. The information gathered will be used to identify promising practices as well as areas of needed improvement. A report of the findings will be developed and shared with the Council members. The following years of the Project will involve the provision of technical assistance to address areas of needed improvement

The Johns Hopkins Department of Pediatrics has revamped its Center of Excellence grant activities funded by the OGCSHCN for the coming year. One of the proposed goals is to increase focus on health care transition in the Harriet Lane primary care clinic, including needs assessment and the training of an adolescent transitions case manager to facilitate transition of youth with certain chronic conditions from the Harriet Lane clinic to adult health care. Further, the University of Maryland Department of Pediatrics has received a small grant from a local foundation to compile information about available health care transition resources and/or programs in Maryland and identify the gaps in services. The OGCSHCN will be participating in this process.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	80	80	85.1	81	83
Annual Indicator	83.3	80.0	80.0	79.9	92.4
Numerator	184009	180072	180072	235885	211932
Denominator	220899	225089	225089	295225	229364
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>

Annual Performance Objective	86.5	86.5	86.5	87	87
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#### **Notes - 2007**

Estimated percentage is based on data from the National Immunization Survey, Q1-Q42007- 92.4% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 0-3 in 2007(Source: Maryland Department of Planning population estimates).

#### **Notes - 2006**

Estimated percentage is based on data from the National Immunization Survey, Q1-Q42006 - 79.9% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 0-3 in 2006 (Source: Maryland Department of Planning population estimates).

#### **a. Last Year's Accomplishments**

According to the Centers for Disease Control and Prevention (CDC)'s sponsored National Immunization Survey (NIS), in 2006, 79.9% of Maryland children ages 19-35 months were fully immunized as defined by the 4:3:1:3:3 series. This percentage slightly below the national average of 80.4% for this time period and meets Maryland's target goal of 80% for this measure. Immunization rates for children in Baltimore City at 76% in 2006 were lower than both the State average and State average outside of Baltimore City (80.5%) according to the NIS. NIS data for the Q32006/Q2007 period, estimate that immunization levels statewide improved to reach 86%.

Immunization issues were included in Maryland's Title V funded early childhood grant development activities. A priority of the Early Childhood Health Plan completed by CMCH in 2007 is to increase access to medical homes for young children. Immunizations are an important component of well child care to be promoted within the medical home. Education about the importance of immunizations as well as new Maryland vaccination guidelines are part of early childhood health outreach efforts.

The Community Health Administration, Center for Immunization is largely responsible for statewide immunization activities in Maryland. Ongoing activities to promote early childhood immunization in FY 2006 included the distribution of immunization educational materials to the parents of every child born in the State, administration of the State's immunization registry, ImmuNet, and operation of the Maryland Vaccines for Children (VFC) Program. VFC allows enrolled physicians to provide all routinely recommended vaccines, free of cost, to children 18 years old and younger who are Medicaid enrolled; uninsured; underinsured or Native American/Alaskan Native. There are currently approximately 750 enrolled providers practicing at 1,000 public and private practice vaccine delivery sites throughout the State. Immunization Excellence Awards are given to VFC providers, who demonstrate excellence in all critical areas reviewed by the VFC Program, including immunization coverage rates of two year olds; and pediatric practice standards.

ImmuNet, the State's immunization registry, began implementation in June 2004. As of May 2007, ImmuNet included 4,000,000 immunization records and was being used in 217 practitioner offices. The registry provides a consolidated vaccination record for children enrolled, provides reminder and recall notices, and prints forms for schools, camps, and day care.

Title V also continued to support local health department efforts to inform consumers, communities and providers about the importance of immunizations. Although the majority of children are immunized in private physician offices, several local health departments continued to offer immunization clinics serving children in underserved areas of the State in 2007. MCH nursing staff in local health departments educated families about the importance of immunizations during home visiting and early childhood programs as part of a comprehensive approach to well child care. Educational materials to promote awareness of the need for immunization continued to be a part of all MCH outreach activities. WIC Program staff determined the immunization status of

their clients at every encounter.

One local health officer initiated an aggressive immunization program for children in the county based on findings from a retrospective survey demonstrating that only 73% of two year olds were adequately immunized. The action plan includes working with the WIC program to identify children with delayed immunizations. MCH staff are also using simplified an immunization schedule cards during nurse home visits and Infants and Toddlers visits. This enables MCH staff to identify children with delayed immunizations and provide education to parents regarding the immunization schedule. Immunization tracking is completed through mailings or visits to physician offices.

DHMH adopted new school immunization requirements for the 2006-2007 school year. Pneumococcal vaccine is now required for children enrolled in preschool programs. As of September 2006, varicella and hepatitis B vaccination became a requirement for all students in preschool through ninth grade. Both CMCH and the Center for Immunization are continued to work with local health departments, health providers and MCIP to educate parents about the new guidelines.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute educational materials to parents of every newborn in the State that includes information on immunizations (Center for Immunizations)			X	
2. Fund local health department immunization clinics and outreach/education activities	X		X	
3. Continue to expand the State's immunization registries, Immunet (statewide) and the Baltimore City registry. Title V supports the Baltimore City registry.		X		
4. Provide insurance coverage for immunizations through Medicaid and MCHP.		X		
5. Administer the Vaccines for Children Program (Center for Immunizations)				X
6. Promote immunizations through home visiting and early childhood programs. Promote access to medical homes for all children through the Early Childhood Health Grant.			X	
7. Screen for immunization status in WIC and other MCH programs.			X	
8. Participate in the Maryland Immunization Partnership.				X
9. Provide outreach and education to the general public and health care providers to improve immunization levels.			X	X
10.				

#### **b. Current Activities**

The Maryland Childhood Immunization Partnership (MCIP) functions as the advisory committee to ImmuNet. MCIP was established by DHMH and the Maryland Chapter of the American Academy of Pediatrics to partner with the Center for Immunization to identify and address issues relevant to implementation of ImmuNet and registry development. In FY 2008, the Early Childhood Health Administrator will begin to represent Title V on the MCIP.

MCIP began offering a Practice Makes Perfect Immunization Training that provides health professionals with comprehensive resources to support promotion and administration of childhood immunizations. This half day training session provides an overview of topics that are

important to safely and effectively provide immunizations, including vaccine recommendations for children, adolescents, and adults; child care and school immunization requirements; vaccine storage and handling; and the Maryland Vaccines For Children Program.

### c. Plan for the Coming Year

During the coming year, the Center for Immunization plans to expand ImmuNet and conduct outreach and education activities directed at both providers and families to improve immunization levels. Strategies will be implemented to increase the immunization coverage rate as measured by the 4:3:1:3:3 series on the National Immunization Survey to 85% by 2020 from a baseline of 73% in 2001. Elimination of the six percentage point disparity in the vaccination rates among racial/ethnic groups will also be addressed. The MCH Program will continue to collaborate with the Center for Immunization on these objectives.

The Title V Program will continue to support immunization outreach and education efforts provided by local health departments. Title V funds will continue to directly support Baltimore City's Immunization Registry, developed independently of ImmuNet. The City's Registry maintains a database of immunization and demographic information on Baltimore City children collected from pediatric providers. MCH staff identify children who are not up to date with their immunizations and refer them to a medical home.

### Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	24.6	24.6	17.9	17.4	16.4
Annual Indicator	18.2	17.9	16.8	17.5	17.5
Numerator	2085	2106	2047	2118	2118
Denominator	114645	117602	121697	121211	121211
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	16.4	15.9	15.9	15.8	15.8

#### Notes - 2007

Source: 2006 Maryland Vital Statistics Report; Data estimated for 2007 and based on 2006 findings.

### a. Last Year's Accomplishments

Maryland's birth rate for teens aged 15-17 rose 4.2% between 2005 (16.8/1000) and 2006 (17.51000), the first such increase since 1991. The increase occurred across all racial/ethnic groups. Racially, the majority of births in this age group occurred to African American teens (55%), followed by white teens (43%). Ethnically, Latino teens represented 17% of births and had the highest birth rate at 50.8 per 1,000 population. Teen Pregnancy prevention efforts are largely addressed and coordinated through two programs: the Maryland Family Planning Program

and the Maryland Abstinence Education and Coordination Program.

In FY 2007, the Family Planning Program served a total of 20, 583 teens ages 15-19 and 1,088 teens under the age of 15 years. Additionally, there was a total of 2,600 youth between the ages of 15 to 19 served in the State's three Healthy Teens and Young Adults (HTYA) sites. These clinics are located in Baltimore City, Prince George's County and Anne Arundel County. HTYA clinical services are offered through model clinics which embrace a comprehensive, holistic approach to health care. The program extends special services to teens and young adults who face social, cultural, institutional, and financial barriers to care. The physical and psychosocial needs of the client are equally considered. Part of this holistic approach includes information and counseling about abstinence and delaying sexual activity in addition to assuring access to contraceptives. The clinics are supported with outreach services based on a philosophy of "Reaching Out/Reaching In." Outreach staff actively reach out to young people where they live, go to school, work, and play. They reach in to young people to develop self-esteem, personal responsibility, and goals for the future.

In 2007, the Maryland Abstinence Education and Coordination Program (MAECP) continued to fund 18 local health departments to provide abstinence education programming. The majority of these jurisdictions supported programs using an after-school program intervention model targeting middle and high school students. MAECP grantees served approximately 2000 youth between the ages of 10--19 years old. Student were taught from a required abstinence curriculum that was supplemented by programming from other curricula promoting positive youth development and decision making. Local activities included development of an abstinence education message that was presented as a movie trailer in local theaters and viewed by 8,000 patrons and student development of promotional abstinence education videos and other media.

A three year contract with the University of Maryland School of Social Work to provide technical assistance and training on techniques and best practices for promoting abstinence and reducing teen pregnancy was initiated in 2007. FY 2007 activities included the development of a "GIRLS RULE" conference targeting middle and high school girls and their parents/caregivers. These conferences offered abstinence and positive life planning messages. The conferences were held on college campuses in three regions of the State and served a total of 672 girls between the ages of 11 to 19 years in 2007. Parents and other professionals who attended these conferences attended workshops designed to assist with parent-child communication. A total of 198 parents and professionals participated in the workshops.

The University also arranged several training events for professionals including a two day conference for abstinence grantees and other youth serving professionals in June 2007. Over 200 professionals attended the meeting entitled, "Healthy Choices: Promoting Healthy Decision Making among Youth."

In light of uncertainty over continued federal funding for Title V abstinence programs, MAECP strengthened efforts to improve coordination and collaboration with community based abstinence education providers. Meetings were held to explore potential partnerships within various state agency agencies including the Department of Human Resources- Foster Care, and the Department of Juvenile Justice. MAECP partnered with Hope Worldwide (a CBAE grantee) and the YMCA to sponsor an abstinence focused youth rally at Dunbar Middle School in Baltimore City. Over 533 youth attended the rally. From this rally, a Youth Ambassador Club was formed and 39 students were trained as abstinence peer educators.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide comprehensive family planning and reproductive health services to approximately 25,000 teens annually.	X			
2. Fund three Healthy Teen and Young Adult Programs promoting a holistic approach to teen pregnancy prevention.	X	X		
3. Administer the federal abstinence education grant. Fund abstinence education programming through grants to local health departments and other community based groups.		X		
4. Conduct training and educational events, including conferences for providers, adolescents and parents/caregivers to promote abstinence and reduce teen pregnancy.				X
5. Collaborate with other agencies to promote positive youth development.				X
6. Monitor data and trends.				X
7.				
8.				
9.				
10.				

#### **b. Current Activities**

At the request of the Governor's State Stat Team, this year, CMCH developed a matrix for prioritizing jurisdictions of greatest need for teen pregnancy prevention resources in the State. Should additional State or federal funding become available, the plan is to potentially use this methodology to target resources. The matrix includes seven factors including teen birth rates, infant mortality rates and high school graduation rates.

For Teen Pregnancy Prevention Month in May 2008, MAECP grantees were asked to implement abstinence focused outreach campaigns, to initiate youth councils or hold focus groups with youth to get their thoughts on ways to promote abstinence and to hold workshops to promote parent/child communication. One example is a youth media project developed by a youth media company, Wide Angle, for Baltimore City's abstinence program that includes posters promoting abstinence among Baltimore youth. The messages were developed by teens. CMCH also worked with the Western Maryland region which has high teen births rates in some communities to hold an Abstinence Youth Summit in June 2008.

The uncertainty over Title V funding has made it much more difficult to manage MAECP. In spite of this, the abstinence education coordinator has been working with various vendors to develop outreach and educational materials, develop an abstinence website with sections for youth, parents and professionals, and promote parent-child communication.

#### **c. Plan for the Coming Year**

MCH plans for the coming year include:

- . Continuing to administer the Maryland Abstinence Program with a focus on strengthening State collaborations, promoting greater parent/child communication, expanding programming to teens with disabilities, involving more youth in program planning,

- . Continuing to provide family planning services and reproductive health programs directed at adolescent pregnancy prevention including Healthy Teen and Youth Adult sites;

- . Working to address the increases in teen pregnancy particularly within the Latino population; and

- . Reviewing the state infrastructure for teen pregnancy prevention activities in Maryland and research best and promising practices nationwide as part of the 2010 Title V needs assessment.

Monitoring and analyzing data and trends.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	30	30	30	30	30
Annual Indicator	23.7	23.7	23.7	23.7	42.2
Numerator	17703	17703	17703	17703	25466
Denominator	74696	74696	74696	74696	60400
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	42.5	42.5	42.5	45	45

**Notes - 2007**

Source: University of Maryland Dental School. Survey of the Oral Health Status of Maryland School Children, 2005-2006 School Year. This is a periodic survey conducted by the University, last conducted in 2001-2002.. Based on weighted prevalence of dental sealants among MD 3rd graders during the 2005-2006 school year.

**a. Last Year's Accomplishments**

Access to oral health care is a critical problem for underserved and minority populations in Maryland. The 2005 - 2006 Survey of Oral Health Status of Maryland School Children, conducted by the University of Maryland Dental School, found that 31% of children in kindergarten and third grade had untreated tooth decay. Children residing on the Eastern Shore and in Southern Maryland had the highest rates of untreated tooth decay. Low-income, African-American and Hispanic children suffer even higher rates of tooth decay than white and upper-income children.

A recent Survey of Oral Health Status of Maryland's Head Start Children conducted by the University of Maryland at Baltimore Dental School, Department of Pediatric Dentistry examined three- and four-year-old children from 37 Head Start programs across Maryland. Head Start is a federally- funded program whose participants must be under 185 percent of the federal poverty level. All children enrolled in Head Start are to receive comprehensive health services, including medical, dental, nutrition and mental health services. In addition, since most of these children are from low-income groups, they are eligible to receive Medicaid services including EPSDT.

The study found that 54.6 percent of the children had decayed or filled tooth surfaces (dfs), with a mean dfs of 3.64. Such high caries prevalence in three and four-year-old children is similar to other reports from Head Start children in the U.S. Children in rural areas experienced a 16 percent greater caries experience and a 27 percent greater numbers of decayed surfaces. This may be due to the fact that children living in rural areas are less likely to drink water from fluoridated community water systems when compared to children from metropolitan areas.

Inadequate access to oral health care, particularly for uninsured and Medicaid clients, continued

as a concern for all areas of the State. In Maryland, 33.7% of Medicaid children are receiving services. Out of 4,033 Maryland dentists, only 661 are actively serving and billing Medicaid recipients.

The Maryland Legislature continued its mandated review of utilization rates of dental health services by children enrolled in Medicaid. One third of enrolled children are receiving a dental service and less than one quarter receive restorative services. This is occurring despite high rates of dental disease among children in Maryland. While Medicaid has been successful in recruiting additional participating dentists in recent years, it is estimated that only 17 percent of the State's dental practitioners are participating providers and less than 9 percent bill more than \$10,000 per year in services to Medicaid.

In 2007, Secretary Colmers convened a Dental Action Committee (DAC) in response to increasing evidence of inadequate access to dental care. The DAC was charged to develop recommendations for improving access to dental services for all low income children. The Committee made 60 recommendations with a goal of establishing Maryland as a national model for children's oral health care. One of their recommendations was to hire a full-time state Dental Director who joined the Department of Health and Mental Hygiene this past January. With the strong assistance and support from federal and state legislative partners, Maryland is moving forward with the recommendations and dental reforms.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with Office of Oral Health, Medicaid and other stakeholders to develop and sustain a statewide Oral Health Coalition focused on improving access to oral health care services and assisting with implementing the recommendation of the Oral Health				X
2. Survey preschool and school aged children to ascertain and monitor oral health status and needs.				X
3. Fund and support a range of oral health services for children in local health departments including diagnostic, preventive and restorative services. Title V supports services in Baltimore City. The Office of Oral Health supports services statewide.	X	X		
4. Plan and promote strategies to improve early childhood oral health.				X
5. Provide insurance coverage for dental health services for children and pregnant women through Medicaid and MCHP.				X
6. Administer a loan repayment program for dentists who serve low income populations (Office of Oral Health).				X
7. Fund school based dental sealant programs.				X
8. Promote the P.A.N.D.A. Project, a child abuse prevention program that trains dentists to recognize abuse.				X
9. Disseminate a Resource guide that identifies discounted and low cost dental health services available to eligible Marylanders.		X		
10.				

#### **b. Current Activities**

Current Activities:

In response to the recommendations of Secretary Colmers and the Dental Action Committee, the 2008 Maryland General Assembly took the following actions:

- . Appropriated \$14 million for the first installment of a three-year effort to bring Maryland Medicaid dental rates up to the 50th percentile of the American Dental Association's South Atlantic region charges.

- . Appropriated \$2.1 million to enhance the dental public health infrastructure and increase access to dental public health services for low-income children. These funds will be used to establish new dental public health clinics and to support school-based dental programs including support for a dental wellmobile.

- . Passed Legislation to create a new "public health dental hygienist" category to enhance the ability of dental hygienists working in public health facilities to provide needed dental screening and preventive services for low-income populations.

Through a partnership with the University of Maryland Dental School and the Maryland State Dental Association, DHMH, is working to develop a training program for physicians and general dentists in the risk assessment and treatment of very young children. Maryland also in the process of establishing a means for pediatricians and family medicine physicians to be paid by the Medicaid Program for assessing and applying a preventative fluoride varnish agent to very young children not currently being seen by dentists.

### c. Plan for the Coming Year

This coming year, the MCH Program will continue:

- . Working with the Office of Oral Health to implement a plan to improve the oral health of children in Maryland. Activities will include (1) working with the Maryland State Department of Education to develop a phased-in multi-year approach to integrate dental screenings into the current vision and hearing screening programs tied to school enrollment and (2) developing a multi-cultural oral health message that reinforces the importance of oral health to the public.

- . Participating in the Maryland Oral Health Coalition;

- . Implementing early childhood health plan strategies that address oral health including completion of a second oral health assessment of Head Start enrollees;

- . Supporting local health efforts to improve access to oral health services for low-income children; and

- . Reviewing oral health data for the Title V needs assessment including examining the results of an evaluation of the State's dental health infrastructure to determine additional avenues for Title V to collaborate with the Office of Oral Health to improve access to dental services for children and pregnant women.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	3.5	3.5	2.6	3	3
Annual Indicator	2.9	3.4	2.4	2.5	2.5
Numerator	33	39	28	28	28
Denominator	1143353	1153514	1153348	1112945	1112945
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5

#### Notes - 2007

Source: 2006 Maryland Vital Statistics Report.

#### a. Last Year's Accomplishments

Injuries, including motor vehicle accidents remained the leading cause of death for children in 2006, a year in which 38 Maryland children under the age of 15 died in motor vehicle crashes. In FY 2007, the MCH Program continued to provide support and technical assistance to state and local Child Fatality Review (CFR) teams legislatively mandated to review child deaths in Maryland including those caused by motor vehicle accidents. Several jurisdictions identified motor vehicle accidents as a priority concern. The 2006 Child Death Report prepared by the MCH Epidemiologist for the state CFR team identified trends in deaths due to motor vehicle accidents.

State activities directed at preventing deaths due to motor vehicle accidents largely fall outside of the purview of the MCH Program. Maryland has enacted several strict safety belt laws. As a result of aggressive enforcement of these laws, Maryland has an 89% seat belt usage rate, one of the highest on the east coast. Children and young people up to 16 years of age must be secured in seat belts or child safety seats, regardless of their seating positions and may not ride in an unenclosed cargo bed of a pick-up truck. Maryland law also strictly forbids driving while impaired by alcohol or other drugs and the minimum lawful drinking age is 21 years.

Maryland law changed this year to read "A person transporting a child under the age of 8 years in a motor vehicle shall secure a child in a safety seat in accordance with the child safety seat and vehicle manufacturers' instructions unless the child is 4 feet, 9 inches tall or taller; or weighs more than 65 pounds" Since the 1980's, the Maryland Kids in Safety Seats (KISS) Program has been the State's lead agency for promoting child passenger safety. KISS is housed in the Family Health Administration's Office of Health Promotion and funded by the Maryland Department of Transportation. Its mission is to reduce the number of childhood injuries and deaths by educating the public (e.g., 1-800 helpline, media campaigns, website) about child passenger safety including the correct use of safety seats.

During National Child Passenger Safety Month in February 2007, jurisdictions throughout the state participated in child safety seat checks and community outreach and education activities. Child safety seat inspections conducted in Maryland reflect that while an estimated 80% of the target population uses child safety seats; the majority (78% in FY 2006 -- most recent data) of these restraints are improperly installed. KISS continued to administer a loaner program that provided child safety restraints to over 1,100 low-income families in FY 2007. In addition, KISS offered child passenger safety certification training to Marylanders including law enforcement personnel.

The Center for Preventive Health Services (CPHS) funds local injury prevention programs, several of which address motor vehicle safety. CPHS also administers a project that links state crash and medical outcome data to identify the medical and financial consequences of motor vehicle crashes. CPHS uses this information to support preventive efforts.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct State and local child fatality review processes that include a review of deaths due to motor vehicle crashes.				X
2. Enforce strict Maryland child safety seat, safety belt and DUI laws.				X
3. Enforce laws requiring children of certain weights and at certain ages to use child passenger safety seats.				X
4. Educate the public about child safety seat laws and the correct use of child passenger safety seats. Administer the Kids in Safety Seats Program that includes a free Loaner Program (Office of Health Promotion).		X		
5. Fund local injury prevention programs promoting motor vehicle safety (Family Health Administration).			X	
6. Monitor data and trends. Publish an annual child fatality review report that includes data on deaths due to motor vehicle crashes.				X
7. Collaborate with other agencies and coalitions (e.g., the Partnership for a Safer Maryland) to reduce injuries.				X
8.				
9.				
10.				

**b. Current Activities**

Ongoing activities are continuing in 2008. The MCH Epidemiologist is currently completing the 2007 Child Fatality Review Report. Once again, the report identifies injuries, including those due to motor vehicle accidents, as a leading cause of child deaths.

**c. Plan for the Coming Year**

In FY 2009, the State Child Fatality Review Team and the MCH Program will continue to partner with other DHMH and state agencies to reduce child deaths due to motor vehicle accidents.

MCH will continue to be represented on the Partnership for a Safer Maryland, a coalition convened by the Center for Preventive Health Services (CPHS) to advocate for injury and violence prevention. The 80 member Coalition will assist in developing and implementing a Maryland Plan for Injury Prevention. CPHS received a five year CDC grant to support building of additional state infrastructure for injury prevention. Reducing childhood deaths and injuries due to motor vehicle accidents is part of the Coalition's focus.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				42	44
Annual Indicator			40.8	40.2	40.2
Numerator			29085	31127	31127
Denominator			71286	77430	77430
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	41	41	41.5	41.5	41.5

#### **Notes - 2007**

Source: National Immunization Survey. Breastfeeding rates for Maryland children born in 2004. Indicates that an estimated 40.2% of Maryland women were breastfeeding at 6 months. This percentage was applied to the number of births in Maryland in 2006. Data for 2007 is currently unavailable.

#### **Notes - 2006**

Source: National Immunization Survey Breastfeeding rates for Maryland children born in 2004. Indicates that an estimated 40.2% of Maryland women were breastfeeding at 6 months. This percentage was applied to the number of births in Maryland in 2006.

#### **Notes - 2005**

Source: % Breastfeeding at six months: CDC National Immunization Survey data applied to estimated number of births in 2005.

#### **a. Last Year's Accomplishments**

According to the CDC's 2006 National Immunization Survey, for births in 2004, 71% of Maryland mothers initiated breastfeeding. Just over 40% continued to breastfeed at six months, with 8.6% breastfeeding exclusively at six months. This proportion of mothers breastfeeding at 6 months increased minimally (2%) statewide over the previous year's reported rate, but increased significantly (41%) in Baltimore City, the State's major urban area. Maryland ranks 28th among the 50 states and the District of Columbia for the percent of mothers who breastfeed their infants at 6 months. The 2006 CDC report showed a continued significant racial disparity in breastfeeding nationwide, with only 61% of Black mothers ever breastfeeding, compared with 76% of white mothers and 81% of Hispanic mothers. Maryland PRAMS data for the same birth cohort showed less racial disparity in the state, with 70% of Black mothers ever breastfeeding, compared with 74% of white mothers and 92% of Hispanic mothers (Maryland PRAMS Report, 2004 Births).

Title V continued to support the agenda of the Maryland Breastfeeding Coalition and its subgroups in FY 2007. The Maryland Breastfeeding Coalition continued its mission "to improve the health of Maryland citizens through collaborative efforts that protect, promote and support breastfeeding." The Coalition maintained a website ( [www.marylandbreastfeeding.org](http://www.marylandbreastfeeding.org) ) with an extensive Breastfeeding Resource Guide for breastfeeding women. The Coalition also continued its professional speakers' bureau on breastfeeding topics, with presentations throughout the State at medical grand rounds, as well as at other professional conferences. Coalition members provided articles on varying aspects of breastfeeding support for publication in the Perinatal Network, an electronic newsletter for the Maryland perinatal community. The Coalition also continued work toward launching a "Breastfeeding-friendly Workplace Initiative" statewide. Returning to work is a frequent reason why women stop breastfeeding early, because of a lack of workplace accommodations for pumping and storing their milk. The goal of the Workplace Initiative is to increase the number of Maryland mothers breastfeeding at 6 months and beyond by encouraging workplace support of breastfeeding employees.

The Coalition identified the following areas for ongoing efforts: 1) community outreach and education, 2) professional education, 3) advocacy, 4) the Maryland Breastfeeding-Friendly

Workplace Initiative, and 5) support for breastfeeding mothers with infants in neonatal intensive care. The Breastfeeding Resource Guide has been completely updated this year and is currently being formatted into a more user-friendly form. Links to other national breastfeeding resources have been expanded. The Coalition's professional speakers' bureau continues to provide breastfeeding education to healthcare professionals in Maryland. The bureau is recruiting nurses, lactation consultants, and dieticians to expand its activities to include those professional groups. Bureau members have received funding from the American Academy of Pediatrics to bring a nationally-known breastfeeding expert to Maryland in March 2009, to give Grand Rounds presentations at the two university medical schools and a large community teaching hospital.

Last year, both the Title V and WIC Programs continued to pro-actively promote and support breastfeeding efforts across the State. Breastfeeding was promoted in Title V funded Improved Pregnancy Outcome Programs found in every jurisdiction in the state. The Medicaid Healthy Start Home Visiting and Case Management Program promoted breastfeeding to enrolled pregnant and postpartum women. Requirements for lactation support in all of Maryland's birthing hospitals remained a part of the Maryland Perinatal System Standards. The WIC Program continued to promote breastfeeding as the preferred method of infant feeding for all clients. WIC has a Breastfeeding Coordinator and all WIC staff have received training in advanced lactation support. WIC continued its Peer Counseling Breastfeeding Support Program in several Maryland counties.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership and staff support for the Maryland Breastfeeding Coalition.				X
2. Disseminate a breastfeeding toolkit for employers to promote breastfeeding in the workplace. Designate worksites as "breastfeeding friendly."				X
3. Conduct outreach, attend health fairs and other educational events to promote breastfeeding. Educate the public about the passage of "Right to Breastfeed" legislation in Maryland.			X	
4. Educate health providers about the benefits of breastfeeding and encourage health providers to promote breastfeeding.			X	
5. Promote the availability of a Breastfeeding Speaker's Bureau.				
6. Update and disseminate a statewide Breastfeeding Resource Guide.		X		
7. Update and maintain the "Breastfeeding in Maryland" website.				X
8. Fund and support breastfeeding promotion activities such as peer counseling programs in local health departments.		X		X
9.				
10.				

#### **b. Current Activities**

In FY 2008, the Maryland Breastfeeding Coalition began an initiative to expand its membership and extend its reach throughout the State. Minority members are being recruited, as are partnerships with minority organizations. Representation from the rapidly growing Hispanic population is actively being sought.

The Maryland Breastfeeding-Friendly Workplace Initiative was launched in February 2008. An employer's toolkit was distributed to dozens of Maryland employers to encourage their support of breastfeeding employees. The toolkit includes information on the benefits of breastfeeding for infants, mothers, and employers. The toolkit also includes information on developing workplace policies to support breastfeeding, and requirements for a breastfeeding support room where

mothers can express their milk during the workday.

A "Breastfeeding-friendly Workplace Award" has been developed, with support of both the Maryland Department of Health and Mental Hygiene (DHMH), and Department of Business and Economic Development (DBED). The award is signed by the Secretaries of both Departments. Several applications for the award have been received and are being processed. Several Coalition members completed the HRSA "Business Case for Breastfeeding" course designed to train individuals to recruit businesses to become breastfeeding-friendly. With the recent renovation of its breastfeeding room, DHMH hopes to become a role model for breastfeeding support in the workplace.

### c. Plan for the Coming Year

During the coming year, the Title V Program plans to continue its ongoing activities that support breastfeeding as the norm for infant feeding in Maryland. Plans for FY 2009 include:

- . Continue to provide leadership and staff support for the Maryland Breastfeeding Coalition.
- . Expand community outreach activities to increase the number of Maryland mothers, of all racial and ethnic groups, who not only initiate breastfeeding but continue breastfeeding for at least 6 months. Examples include activities at health fairs, community events, ethnic street fairs, faith-based organizations, etc.
- . Provide outreach and technical assistance to local health departments and other state agencies to implement breastfeeding promotion activities appropriate to their area of responsibility.
- . Recruit businesses in the State to become breastfeeding-friendly workplaces.
- . Recognize successful breastfeeding-friendly workplaces with the Maryland Breastfeeding-friendly Workplace Award.
- . Showcase successful breastfeeding-friendly workplaces by media events.
- . Explore options for implementing a Breastfeeding Awareness Campaign in Maryland media markets. This would include identifying an influential spokesperson for breastfeeding promotion. Through such a campaign, encourage positive media portrayals of breastfeeding as the norm for infant feeding in Maryland.
- . Expand awareness in the state of Maryland laws protecting the right to breastfeed.
- . Continue to educate health providers about the benefits of breastfeeding and encourage their promotion of breastfeeding.
- . Maintain and expand the Maryland Breastfeeding website.
- . Continue to identify other funding sources to address breastfeeding promotion activities.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	90	90	90	90	90
Annual Indicator	93.7	91.2	88.5	89.4	92.5
Numerator	66297	64793	62870	64657	68622
Denominator	70783	71083	71013	72345	74196
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	90	90	90	90	90

#### **Notes - 2006**

Newborn hearing screening data is reported by fiscal year, FY 2006.

#### **Notes - 2005**

The denominator is occurrent births for FY 2005.

#### **a. Last Year's Accomplishments**

In FY 2007, 90.2% of the babies born in Maryland were screened for hearing loss prior to discharge. Additionally, another 1,726 newborns that were missed prior to discharge were seen for an outpatient hearing screening. Thus, 92.5% of the babies born in Maryland underwent hearing screening. Eighty six percent of the babies screened, passed their hearing screening prior to discharge. Of those that returned for an outpatient hearing screening, 92% passed. Unfortunately, 6,741 infants (9%) were lost to follow up.

It is suspected that one of the culprits of losing babies to follow up is inadequate data management. Currently, hearing screening results are added to the metabolic blood spot card which is then sent to one of two laboratories where the results are hand keyed into the respective lab's data base, and the results are then uploaded into the Infant Hearing database on a daily basis. Through that long path information can easily be lost or incorrectly entered. Wanting to shorten the results journey and improve efficiency and accuracy, an RFP was submitted for a new online data management system. The RFP resulted in an award in March, 2007 to the Oz Systems Corporation. Training of birthing hospital began in May, 2007 and full implementation into the birth hospitals is expected to be completed by August, 2008.

Also, in 2007 an office secretary was hired and full time PINs were secured for two of the Infant Hearing staff. For the first time in many years, the Program is fully staffed and only one position remains a contract position. It is expected that a stable full staff compliment will have a significant impact on improving statistics and program effectiveness.

Efforts were focused on improving communication between providers and the State. A statewide stakeholders meeting was held to address newborn hearing screening issues and present the new Maryland Newborn Hearing Screening Guidelines. The meeting was attended by over 50 hospital technicians, nurses, audiologists, and early interventionists across the state. New brochures and educational materials were developed for both providers and families and have been made available on our website. Continuing efforts are being made to improve and upgrade the Infant Hearing website. The program continues to publish an electronic newsletter for stakeholders on a quarterly basis.

Grants were awarded to the Maryland School for the Deaf and the Maryland State Department of Education for a joint two part workshop for early interventionists and families with children with hearing loss. The workshops were well attended and well received by the 50+ participants.

In an effort to improve communication between state entities and gather outcome data, an MOU was established between the Infant Hearing Program and the MD School for the Deaf. Babies that are identified with hearing loss through the MD EHDI program will be matched with MSD enrollments to determine if early intervention services are being initiated. It is also anticipated that this information will be helpful in identifying populations and geographic areas that are at risk for delayed or no early intervention services.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support hearing screening for all Maryland newborns.	X		X	
2. Provide tracking and follow-up on all screening referrals and not tested infants to confirmation of hearing status.	X	X	X	
3. Educational materials regarding hearing screening for parents, families, and providers developed and available		X	X	X
4. Educational materials developed and available for parents regarding hearing evaluation and developmental milestones in multiple languages for provider use.		X	X	X
5. Enhance the program's website to include educational brochures and reporting forms in downloadable format for providers and families		X	X	X
6. Birthing facilities provided with site evaluations	X	X	X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

Since March 2008 the Program has been deeply entrenched in implementing the eSP online data management system. After initial customization, 4 birthing hospitals were selected to serve as test sites. After a six week long live test and positive reports from all four sites and IH staff, training of the remaining hospitals began. Since June 2008 25 birthing hospital's screening staff have been trained on the new system and are utilizing the system for the reporting of all their hearing screening results. It is anticipated that the remaining 11 hospitals will be trained and up and running by August 2008.

During all this change the Infant Hearing staff continues to monitor the statewide Newborn Hearing Screening Program and facilitate appropriate follow up care for the 75,000+ newborns born in Maryland and their families. In house procedural changes have been initiated to improve timely follow up by raising the Program's visibility to providers, assigning specific staff members as contacts with specific hospitals, instituting routine scheduled contact with birthing facilities, and annual hospital site visits.

**c. Plan for the Coming Year**

Plans are currently underway to train the audiology and medical home communities on the new eSP data management system. Having a secure password and access to this online data management system will allow providers to enter hearing test results and intervention information into the data base and enable them to follow the course of diagnosis and treatment of their patients.

The OGCSDCN will continue to partner with other agencies in the community to provide professional and family education and support. A joint venture is being planned between the Maryland State Department of Education and the Maryland School for the Deaf to provide two regional workshops in different parts of the state on family support.

Plans to bring attention to early hearing identification and intervention will continue through presentations at professional conferences, the Infant Hearing Newsletter, exhibits at professional meetings, health fairs, and community meetings.

Tracking and surveillance work of the newborn hearing screening program will continue. Additionally, evaluations of the new online data management system will be on going to evaluate

effectiveness and institution of appropriate changes to meet the expected outcome of hearing screening for all newborns one month of age, identification by three months of age for infants that do not pass screening, and early intervention initiation by six months of age for deaf and hard of hearing infants.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	10	10	9.5	9.6	9.6
Annual Indicator	9.6	9.6	9.6	12.0	12.0
Numerator	140000	133902	133902	163264	163264
Denominator	1452879	1394808	1394808	1360531	1360531
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12.1	12.1	12.1	12.1	12.1

**Notes - 2007**

Source: Maryland Health Care Commission, Maryland Health Insurance Coverage in 2005-2006, issued November 2007. Estimates that 12% of children under the age of 19 in Maryland are were uninsured. Based on findings from the March 2007 Bureau of the Census revised Current Population Survey estimates. Estimate based on 2005-2006 findings since data for 2007 is currently unavailable.

**Notes - 2006**

Source: Maryland Health Care Commission, Maryland Health Insurance Coverage in 2005-2006, issued November 2007. Estimates that 12% of children under the age of 18 in Maryland are were uninsured. Based on findings from the March 2007 Bureau of the Census revised Current Population Survey estimates. Population estimate from 2006 Vital Statistics report for ages 0-17.

**Notes - 2005**

Data for 2005 is unavailable. Estimate is based on 2004 data from the Census, Current Population Survey data for Maryland.

**a. Last Year's Accomplishments**

An estimated 750,000 (15.2%) Marylanders under the age of 65 lacked health insurance coverage in 2005-2006 according to a Maryland Health Care Commission report based on data from the Census Bureau's Current Population Survey. Approximately 12% of the State's uninsured were children under of the age of 19. Medicaid and MCHP are partially credited with a Maryland trend towards decreasing numbers of uninsured children. Black (40%), Hispanic (17%) children were more likely than White children (37%) to be uninsured in 2004-2005 according to the Maryland Health Care Commission.

Medical Assistance and the Maryland Children's Health Insurance Program (MCHP) continued to

provide health insurance coverage for low income children. MCHP, which is administered by the Medicaid Program, provided access to health insurance coverage for significant numbers of uninsured Maryland children in families with incomes up to 300% of the poverty level. MCHP Premium serves children in families with incomes between 200% and 300% of the federal poverty level. Enrolled families pay a monthly contribution. During federal fiscal year 2007, enrollment in MCHP exceeded 130,000 while Medicaid provided coverage to 400,000 children.

The Children's Medical Services Program within the OGCSHCN provides coverage for specialty care for uninsured and underinsured CSHCN in family incomes below 200% of the federal poverty level. Since Medical Assistance also covers this same income group, most of the children served are undocumented.

The MCH Hotline (1-800-456-8900) refers families to local health departments to receive assistance in determining their eligibility for Medicaid and MCHP programs. During Child Health Month and other special observances, the CMCH Outreach Coordinator works closely with local health agencies to distribute pamphlets and other materials that promote Medicaid and MCHP. Resource guides, brochures and fact sheets are periodically distributed by CMCH at health fairs and community events.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer families to Medicaid and medical services through the MCH Hotline.		X		
2. Provide health insurance coverage for eligible low income children in families with incomes with to 300% of the federal poverty level through Medicaid and MCHP.		X		
3. Provide coverage for eligible CSHCN through the Office for Genetics and Children with Special Health Care Needs.		X		
4. Provide outreach to enroll eligible children into Medicaid and MCHP. Disseminate resource information, including sources of financial assistance for health care at health/community fairs and other outreach events (MCH staff in local health departme		X		
5. Assess health needs and issues confronting uninsured children and families including geograhic and racial/ethnic disparities.				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The 2008 legislative session passed the Kids First Act to improve outreach to uninsured children. This legislation requires the State Comptroller to provide notice of a child's potential eligibility for Medicaid or the Maryland Children's Health Program. The Maryland Legislature also enacted the Working Families and Small Business Health Care Coverage Act during a Special Session in the fall of 2007. This new law is expected to provide access to health insurance coverage to an additional 100,000 adult Marylanders.

#### **c. Plan for the Coming Year**

In FY 2009, State and local MCH programs will continue to support the Medicaid Program in enrolling eligible children and adolescents. Outreach strategies will include distributing MCHP/Medicaid eligibility information to schools, licensed day care centers, Head Start programs, and at community events and health fairs. As funding allows, periodic media campaigns will be used to promote the MCH Information and Referral Hotline. The MCH Hotline will continue to refer pregnant women and families to local health departments and other program sites that determine eligibility for Medical Assistance Programs.

Reforming the health care system to reduce the numbers of uninsured in Maryland is a priority of the new Health Secretary. In preparation for the 2010 MCH needs assessment, a planning group will begin reviewing data on the uninsured children and families in Maryland and assessing the State's capacity to reduce the numbers of uninsured children and women of childbearing age.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				32.5	32.5
Annual Indicator			33.0	33.0	33.0
Numerator			10944	10944	11881
Denominator			33164	33164	36002
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	32.5	32	32	32	32

**Notes - 2007**

Source: Maryland WIC Program data. Maryland WIC estimates for 2007 based on enrollment and BMI analysis for the period, July-December 2007.

**Notes - 2005**

Source: Maryland WIC Program, BMI Summary Data, Jan-June 2006.

**a. Last Year's Accomplishments**

Childhood overweight/obesity was identified as a priority issue during the 2005 Title V needs assessment. It was a major theme heard in focus groups with parents who expressed concerns about their own overweight children and/or the number of overweight children living in their communities. Contributing factors were thought to include poor food choices in schools, reductions in physical education classes, and large food portion sizes served in restaurants.

Surveillance data on overweight/obesity among Maryland children and adolescents is limited, but improving. In 2007, activities continued to focus on improving access to data sources for measuring the nutrition and physical activity patterns of Maryland children. Data sources include the YRBS survey which provides nutrition and physical activity data on teens in grades 9 to 12; parental reports of child height and weight to be obtained from the BRFSS; pilot testing of a methodology for collecting BMI data from a sample of office based physicians; Medicaid data

from chart reviews and BMI data collected by the WIC Program. WIC Program data for 2005 show that 16% of two to five years old WIC enrollees were overweight. Another 16% were identified as at risk for obesity and 4% were determined to be underweight.

The 2003 National Children's Health Survey provides statewide estimates of the percentage of children, ages 10-17, at risk for and currently overweight. An estimated 13.3% were overweight and another 16.6% were at risk for being overweight. Black (42%) and Hispanic (32%) children were more likely than White (24%) children to be overweight/obese.

The Office of Chronic Disease Prevention (OCDP) addresses chronic disease prevention and has lead responsibility for overweight/obesity reduction in Maryland. CMCH continued to partner with CPHS to address childhood obesity through strategic planning, surveillance, provider education and promotion of public awareness in 2007. Dr. Cheryl DePinto leads childhood obesity reduction activities for CMCH and serves as the liaison to OCDP.

A CDC nutrition and physical activity grant supported the completion of a statewide strategic plan to address rising obesity rates among adults and children. Maryland is using this report as a starting point for developing programs to improve healthy eating habits and levels of physical activity. The Plan's goals and objectives stress population focused prevention efforts to reduce environmental barriers and support healthy food choices and physically active lifestyles. Dr. DePinto represented CMCH on the Planning Committee that developed the State Plan.

Plan objectives include:

- . To increase breastfeeding rates (e.g., initiation among African American women; exclusive breastfeeding at six months and beyond);
- . To increase student engagement in moderate physical activity for at least 30 minutes for five days per week and reduce television viewing;
- . To increase fruit and vegetable consumption among students; and
- . To develop, maintain and/or enhance surveillance systems.

On June 6, 2007, the Maryland Healthy Eating and Active Lifestyle Coalition with support from the Center for Preventive Health Services sponsored the first Maryland Obesity Symposium. The Symposium's purpose was to raise awareness about trends in overweight and obesity in Maryland; highlight preventive interventions and Maryland research efforts; and to identify new partners for networking and coalition building. Dr. DePinto gave a talk entitled "More Than Numbers: Overweight and Obesity in Maryland." Her talk highlighted significant racial/ethnic/gender/SES disparities in obesity/overweight.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Office of Chronic Disease Prevention, WIC and others to plan and implement strategies to reduce childhood overweight and obesity.				X
2. Implement child and adolescent health components of the State's most recent Nutrition and Physical Activity Plan.				X
3. Work with the Academy of Pediatrics, Medicaid and others to improve surveillance.				X
4. Promote awareness of childhood overweight and obesity among health providers, families and the general public through presentations at conferences, funding of pilot programs and conduct of educational sessions.			X	
5.				

6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

During the 2008 Legislative Session, a bill passed calling for the establishment of a Committee on Childhood Obesity within the Department of Health and Mental Hygiene. This Committee is charged to report on (1) the insurance reimbursements paid to health care providers to diagnose and treat childhood obesity; (2) a system for collecting, analyzing and maintaining statewide data; (3) best and promising practices; (4) methods to enhance public awareness of the chronic diseases related to childhood obesity; and (5) methods to increase the rate of obesity screenings for children. Lead administrative responsibility for this Committee rests with the Office of Chronic Disease Prevention within the Family Health Administration. Dr. DePinto has been asked to serve as an Expert Advisor to the Committee.

#### **c. Plan for the Coming Year**

Planned activities for 2008 include continuing to work with the Healthy Eating and Active Lifestyle Coalition to promote healthy eating and active lifestyles for all Marylanders. In addition, the Title V agency will continue to work with the Committee on Childhood Obesity as it prepares its report to the Legislature which is due by December 1, 2009.

Data on obesity among children and adolescents remains sparse. In 2002, CMCH facilitated a statewide meeting of experts and stakeholders to develop recommendations for reducing childhood obesity. Childhood surveillance data was identified as a major unmet need. The Title V Agency will continue to work with the Department of Education, Medicaid and the Maryland Academy of Pediatrics to explore ways to improve childhood overweight/obesity surveillance. The MCH epidemiologist is currently working with Dr. DePinto and the Medicaid Program on a study of childhood obesity among children enrolled in Medicaid managed care programs. The intent is to use the findings to develop a quality improvement approach to addressing obesity prevention and treatment based on the most recent national clinical recommendations for assessing treating childhood obesity.

Planning for the 2010 MCH needs assessment will continue in 2009. Data from various sources including the WIC Program, the YRBS, Medicaid and the BRFSS will be compiled to present a profile of the status obesity and overweight among children, adolescents and women of childbearing age in Maryland.

#### **Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

##### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				10.9	10.7
Annual Indicator			11.1	7.8	7.8
Numerator			8270	6040	6040
Denominator			74500	77430	77430
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	7.6	7.6	7.6	7.4	7.4

#### Notes - 2005

Source: 2003 Maryland PRAMS Report, 11.1% of respondents reported smoking during the last three months of pregnancy. Number of women refers to number of births in 2004. 2004 or 2005 PRAMS data is not currently available.

#### a. Last Year's Accomplishments

Data from the Maryland Behavioral Risk Factor Surveillance System (BRFSS) Database indicate that 8 percent of pregnant women smoked in 2007. Prenatal smoking rates varied by jurisdiction and tended to be higher in jurisdictions where higher percentages of low income women lived. Data from the 2006 Maryland Pregnancy Risk Assessment Monitoring System (PRAMS) survey indicates that almost 8% of Maryland women smoked during the last three months of pregnancy. Smoking rates varied by socio-demographic factors and were highest for white women, young women under the age of 25 and women with less than a high school education.

Data from the Maryland Prenatal Risk Assessment Dataset indicate that low-income pregnant women were more likely than pregnant women in the general population to smoke prenatally. This database reported that 22% of the 17,883 pregnant women referred to local health departments through the Prenatal Risk Assessment process were tobacco users in FY 2007. (The Prenatal Risk Assessment Form is completed by health providers serving predominantly Medical Assistance and low income women in the State. The database included approximately 23% of the State's pregnant women in 2007).

The Maryland Center for of Health Promotion, Education, and Tobacco Use Prevention is the lead agency responsible for smoking cessation activities in DHMH. This Center administers the Smoking Cessation in Pregnancy (SCIP) Program as well as Cigarette Restitution Funds (CRF). SCIP is a multi-component program that trains local health department and Medicaid managed care staff to facilitate smoking cessation among pregnant women and women considering pregnancy. Women smokers meet with public health nurses who counsel them to quit or reduce tobacco use. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a "Quit Kit." In FY 2007, approximately 1,200 Quit kits and 800 brochures were distributed, as well as over 700 other promotional items for the public. The Center updated its SCIP Booklet in Early 2008 to reflect more current data and information.

Cigarette Restitution funds are awarded to every jurisdiction in the State to fund awareness, prevention and cessation programs. The CRF Program also manages a statewide "Quit Line" and website, conducts surveillance, supports community coalition and funds regional groups to provide outreach and technical assistance to minority groups.

During FY 2007, local health departments continued to promote smoking cessation during pregnancy as a part of preconception health counseling during family planning clinic visits. Some clinics supplied nicotine patches and/or Zyban to clients. Educational materials promoting smoking cessation were also offered during home visits and at health fairs and other educational events. Local health departments continued to partner with groups such as the March of Dimes to educate pregnant women about the health risks linked to smoking during pregnancy.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Monitor trends in smoking rates during pregnancy using several data sources including PRAMS and birth records.				X
2. Promote smoking cessation during preconception health counseling in family planning clinics, during local health department prenatal care clinic visits and during prenatal and postpartum home visits.		X		
3. Refer women of childbearing age who smoke to smoking cessation programs including the Smoking Cessation in Pregnancy Program (SCIP) administered by the Office of Health Promotion.		X		
4. Promote smoking cessation in schools.			X	
5. Enforce Maryland laws enacted to eliminate smoking in schools.				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

In 2008, CMCH continues to collaborate with multiple intra and inter-agency groups include the Center for Health Promotion, the American Lung Association, private providers, community-based organizations and the American College of Obstetricians and Gynecologists to promote strategies to reduce smoking during pregnancy.

In 2008, the Cigarette Restitution Fund Program will conduct a statewide tobacco use survey to track smoking patterns among adults and adolescents to evaluate program accomplishments. This data will be reviewed by the MCH Program and reported on in the 2010 Title V needs assessment.

On February 1, 2008 the Maryland Clean Indoor Air Act took effect. This Act bans smoking in bars and restaurants statewide and is designed to protect workers and patrons, many of whom are pregnant women, from the dangers of secondhand smoke.

#### **c. Plan for the Coming Year**

In 2009, CMCH plans to use the PRAMS dataset to complete additional analyses on smoking during pregnancy. In a recent PRAMS analysis, postpartum depression was found to be associated with increased smoking both during pregnancy and in the postpartum period.

The Center for Health Promotion, Education and Tobacco Use Prevention, has developed the Body Sense Program with the goals of educating female teen smokers about smoking related health risks, motivating them to quit, and providing support for them to quit successfully and maintain a smoke-free lifestyle. Counseling is offered to teenage girls receiving family planning services from one of Maryland's local health departments.

Training is offered to local health departments and health centers that wish to educate and counsel teens about smoking.

The program uses a self-help tool in the form of an upbeat, colorful newsletter which explores the relationship between tobacco use and health issues of concern to teen girls, such as weight loss and skin care. Nurses distribute the newsletter during counseling sessions. Participants are encouraged to read the newsletter complete the enclosed evaluation card and return the card to clinic staff for a small incentive. The cards are returned to the Center for Health Promotion for

evaluation. The Title V Program plans to work with the Center in the coming year to promote this Program to teens in high risk areas of the State.

Other ongoing activities will continue in 2009.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	5.2	5.2	5.9	4.7	4.6
Annual Indicator	6.2	4.8	6.2	4.2	4.2
Numerator	24	19	25	17	17
Denominator	386908	396044	405382	406425	406425
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	4.1	4.1	4.1	4.1	4.1

**Notes - 2007**

Estimate based on 2006 data. Data for 2007 is currently unavailable.

**a. Last Year's Accomplishments**

Homicide and suicide are leading causes of deaths among adolescents in Maryland. Seventeen adolescent between the ages of 15 and 19, committed suicide in Maryland in 2006, a rate of 4.2 deaths per 100,000 youth. The suicide rate decreased for the age group since 2003 when the rate was 4.8 deaths per 100,000 youth following and increase in 2005 to a rate of 6.2 per 100,000.

The Maryland Mental Hygiene Administration (MHA) has lead responsibility for administering programs to prevent adolescent suicide among youth and young adults ages 15-24. Maryland is nationally recognized as a leader in reducing adolescent suicide rates among this age group. For the past 13 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland. During October, MHA sponsors an annual conference on youth suicide prevention and oversees a Youth Crisis Hotline. Funds are also awarded to local school districts to sponsor educational events. A full time Youth Suicide Prevention Coordinator supports these activities.

Maryland was the first State in the nation to offer a toll free decentralized hotline service to address the needs of troubled youth. The 24-hour toll free Youth Crisis Hotline (1-800-422-0008) is staffed by trained counselors and uses a decentralized system which enables the counselor to access or refer the youth to local agencies for assistance. Throughout its 15 year history, the hotline has been very successful in intervening with youth considering suicide.

The Adolescent Health Coordinator continued to represent the Title V agency on the Governor's Inter-Agency Workgroup on Youth Suicide Prevention in 2007. This workgroup assists the Mental Hygiene Administration with youth suicide prevention activities.

YRBS data, available statewide for the first time in 2006, helped to paint a better picture of the magnitude depression and suicide among adolescents in Maryland. These data indicated that:

- 30% of high school students reported feeling sad or hopeless, a proxy measure for depression. Rates were higher for females (38%) than males (22%).
- 17% reported seriously considering suicide, while 12% indicated making a suicide plan.
- 9% reported attempting suicide with females (12%) twice as likely as males to report an attempt.
- 2% reported being treated by a doctor or nurse following a suicide attempt.

YRBS data for the most recent 2007 survey is not yet available.

In July 2007, the MCH Program sponsored a day long session on the prevention of suicide in the school setting as part of the State's annual four day School Health Institute. This session provided participants with a greater understanding of the hidden emotional challenges faced by school aged children that too often lead to suicidal thinking. Strategies that schools can adopt to meet the growing academic and mental health demands of children were discussed. This session was so well received there is a plan to repeat this session at the 2008 School Health Interdisciplinary Program (SHIP) on August 4th through August 7, 2008.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct State and local child fatality review processes that include suicide prevention.				X
2. Co-sponsor and participate in planning for the annual statewide youth suicide prevention conference.				X
3. Work with the Mental Hygiene Administration's Youth Suicide Prevention Program to develop a statewide plan and promote school based prevention activities.				X
4. Administer a statewide Youth Crisis Hotline (Mental Hygiene Administration).		X		
5. Collaborate with other stakeholders to promote positive youth developments through initiatives such as Ready by 21.				X
6. Assess and monitor data on youth suicide and related factors.				X
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The Adolescent Health Coordinator and the State's Child Fatality and Fetal and Infant Mortality Review Coordinator are representing MCH on the Maryland Committee on Youth Suicide Prevention which is currently working to update the State's Youth Suicide Prevention Plan, "For a Better Tomorrow: A Plan for Youth Suicide Prevention in Maryland." This plan originated from a Gubernatorial Task Force, "Child, Teenage and Young Adult Suicide and Other Associate Mental Health Problems" (Governor's Task Force on Youth Suicide Prevention -- July, 1987). The Plan was completed in May 2008, and has been submitted to the Governor's Sub-Cabinet for Children and Youth for approval. Planning is also proceeding on this year's Youth Suicide Prevention Conference.

#### **c. Plan for the Coming Year**

The Mental Hygiene Administration, in collaboration with the Governor's Interagency Workgroup on Youth Suicide Prevention and CMCH, will continue to plan and implement the annual statewide adolescent suicide prevention conference, periodic media campaigns and school based youth suicide prevention programs.

The 20th Annual Suicide Prevention Conference is scheduled for October 8, 2008. This year's theme is :In Our 20th Year: Building a Culture of Hope. " Title V funds will continue to be used to help in underwriting conference costs.

Finally, the MCH Program will review vital statistics data, YRBS results and data from other sources to gain a better picture of the magnitude of youth suicide and related factors (e.g., depression) in Maryland as part of the 2010 MCH needs assessment.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	90	90	87.5	89.5	89.6
Annual Indicator	87.0	89.3	88.7	87.8	87.8
Numerator	1080	1180	1070	1138	1138
Denominator	1242	1322	1206	1296	1296
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	89.7	89.8	90	90	90

**Notes - 2007**

Based on 2006 Maryland Vital Statistics data. Data for 2007 is currently unavailable.

**Notes - 2006**

Source: Maryland Vital Statistics Administration. Defined as vlbw admissions to Level III hospitals in MD and excludes 42 cases for whom status was unknown.

**a. Last Year's Accomplishments**

DHMH continued to work to improve hospital specific birth outcomes and to lower neonatal mortality rates by ensuring that all very low birth weight infants are born at the appropriate subspecialty center. In 2006, according to the Vital Statistics Administration, 90% of very low birth weight infants born in Maryland were delivered at high risk Level III facilities. Another 7.6% were born at Level II facilities and 26 infants (2.3%) were delivered at Level I hospitals

Maryland Perinatal System Standards were originally developed in 1995 by a departmental advisory committee as a set of voluntary standards for Maryland hospitals providing obstetrical and neonatal services. The Standards have been incorporated into the regulations for perinatal referral centers by the Maryland Institute of Emergency Medical Services Systems (MIEMSS) as well as into the Maryland Health Care Commission's State Plan regulations for obstetrical units and neonatal intensive care units.

The Maryland Institute for Emergency Medical Systems (MIEMSS) is responsible for the designation and verification of hospitals as Perinatal and Neonatal Specialty Referral Centers. Specialty referral centers can receive interfacility transports. MIEMMS performs site visits as a part of the designation process. In FY 2006, MIEMSS began the five year cycle for Perinatal Center re-designation process beginning with the Level IIIC Perinatal Referral Center and continuing through FY 2008 with the Level III a and III b centers. The site review team includes the Medical Director for CMCH and the Director of the Family Health Administration. The Review Team is responsible for studying each hospital's application and the designation standards, inspecting the hospital's physical plant, interviewing hospital team members and management personnel and examining perinatal documents (e.g., patient care records and protocol manuals).

Title V funding to the University of Maryland supported a statewide telemedicine program offering obstetrical provider and patient education and outreach consultation. The telemedicine consultative component enhanced direct perinatal provider outreach by allowing increased access to obstetrical consultations while allowing rural patients to remain in their communities rather than traveling long distances to metropolitan areas of the State.

In conjunction with Vital Statistics Administration, the Center for Maternal and Child Health, continued to distribute hospital specific infant mortality statistics for very low birth weight births. Hospital presidents/CEOs were provided outcome data specific to their own to hospitals for their review and were encouraged to share this information with their hospital staff.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review, update and disseminate perinatal care standards through PCAC.				X
2. Provide technical assistance to improve compliance with perinatal standards.				X
3. Collect and analyze perinatal data.				X
4. Work with the Patient Safety Center to improve quality of care in hospital settings.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

In 2008, DHMH implemented a Perinatal Health Collaborative with the Maryland Patient Safety Center. The Maryland Patient Safety Center is a collaboration between the Delmarva Foundation, and the Maryland Hospital Association. The Collaborative includes 25 member hospitals, brought together to focus on improving patient safety in labor and delivery units. Hospital teams are looking to enhance communication between the various providers interacting with patients by standardizing communication with the implementation of SBAR, or Situation, Background, Assessment, and Recommendation. Other activities include education around electronic fetal monitoring, team building, and operational measures such as increasing the number of patients in the labor and delivery unit whose chart includes the prenatal record.

Additionally, the Perinatal Collaborative is partnering with the National Perinatal Information Center to do pre and post-intervention data analysis. Collecting these data will allow the hospitals to assess their own improvements as well as compare themselves to their colleagues.

In April 2008, the Department of Health and Mental Hygiene reconvened the Perinatal Clinical Advisory Committee (PCAC). This multidisciplinary Committee represents 20 Maryland professional organizations and is charged with reviewing and updating the Maryland Perinatal Standards. The PCAC will review the current guidelines to ensure they are consistent with AAP and ACOG standards.

### c. Plan for the Coming Year

CMCH, will continue to its involvement with the Maryland Patient Safety Center and will monitor the Project's progress including the data that will be submitted by the hospitals to the National Perinatal Information Center. CMCH expects to build on the Safety Center's work to improve perinatal outcomes in hospitals. One expected outcome is the development of a network for sharing best practices among hospitals and facilitating interaction with Fetal and Infant Mortality Review and Maternal Mortality Review programs. Findings will be shared through the Perinatal Health Collaborative to promote systems improvements.

In addition, the Maryland Patient Safety Center is in the early stages of planning a Neonatal Collaborative of which the CMCH will be an active participant. This new collaborative will build on the success of the Perinatal Collaborative by enhancing professional communication and encouraging collaboration around improving neonatal health outcomes.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	90	90	83.9	82.3	82.4
Annual Indicator	83.7	82.3	81.3	81.7	80.5
Numerator	61834	60235	59896	62261	62068
Denominator	73876	73230	73678	76248	77067
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	81	81.5	82	82.5	82.5

### Notes - 2007

Source: Maryland Vital Statistics Adm., Preliminary Report, 2007. The denominator excludes 987 births for whom the prenatal care status was unknown.

### Notes - 2005

2005 data is unavailable. 2004 data is used as an estimate.

### a. Last Year's Accomplishments

The State's early prenatal care rate continued to decline to 80.4% in 2006; 8.5% percentage points lower than the 1997 rate of 88.9%. Early prenatal care percentages declined for women enrolled in both Medicaid and non-Medicaid programs. According to Maryland Vital Statistics, in 2006 early prenatal care rates were lowest for Hispanics (63%) followed by African Americans (74.6%).

The Healthy People 2010 goal is for 90% of women to initiate prenatal care within the first trimester. In 2006, four counties (Anne Arundel, Carroll, Howard, and Queen Anne's) met or surpassed the 2010 goal. By race/ethnicity, the goal was met for White, non-Hispanic women. In two jurisdictions, early prenatal care percentages fell below the 2010 goal by 15% or more -- Baltimore City (75.2%) and Prince George's County (71.1%).

PRAMS data for 2003-2006 have demonstrated consistent trends in why women delay receiving prenatal care. Commonly cited reasons include: couldn't get an earlier appointment, didn't have insurance or enough money, doctor or health care plan would not start care earlier, did not have a Medicaid card, or not aware of the pregnancy/keeping the pregnancy a secret. Additionally, FIMR findings have suggested that many women are unable to find a provider to schedule an appointment. Some women are undocumented immigrants and have been placed on waiting lists for existing no-cost prenatal clinics which are unable to accommodate these women. In 2006, Maryland initiated a second effort to improve birth outcomes, named Babies Born Healthy. The Babies Born Healthy Initiative received support as a result of the State's rising infant mortality rate. Because of the complexity of lifetime events that may contribute to a poor pregnancy outcome, Babies Born Healthy provides interventions in each of the four phases: (1) preconception/ interconception; (2) prenatal; (3) perinatal; and (4) postneonatal.

In 2007, the Babies Born Healthy Initiative worked to improve perinatal health through a comprehensive approach. Babies Born Healthy Initiative activities include expansion of the University of Maryland's Maryland Advanced Perinatal System Support, a pilot program using telemedicine to provide high-risk obstetric care to women in rural areas of the State. Baltimore City's Healthy Start, Inc. (BCHSI) Program has used community health workers to provide enabling services to pregnant and post-partum women in at-risk communities since 1991. Baltimore City's Healthy Start, Inc. is seeking to expand their services into additional Baltimore City communities, and MCH is supporting them to conduct a needs and capacity assessment.

Additional strategies include building local and State partnerships to improve birth outcomes by promoting access to prenatal care, providing enabling services (e.g., prenatal education, family support services) to high risk African American and low-income women, expanding access to preconception and prenatal health services and strengthening FIMR. One example of this is the MCH -- WIC (Women, Infant, and Children) initiative designed to ensure preconception health of women by linking MCH and WIC services.

The Title V supported Improved Pregnancy Outcome and Crenshaw Perinatal Health Programs and continued to promote early prenatal care. State and Medicaid funded Healthy Start nurses and other home visiting programs continued to promote access to early and continuous prenatal care, especially among high risk pregnant women. Home visiting and case management services for pregnant women were offered in every Maryland jurisdiction. The MCH Hotline continued to refer pregnant women to prenatal care providers in FY 2007.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer women to prenatal care services through the MCH Hotline.		X		
2. Promote the importance of early prenatal care in home visiting		X		

and care coordination programs.				
3. Offer preconception health counseling in family planning programs that support early prenatal care and healthy habits before pregnancy.		X		
4. Fund local health department based prenatal care services for low income uninsured and/or immigrant pregnant women.	X			
5. Implement the Babies Born Healthy Initiative which promotes healthy birth outcomes by promoting strategies such as improved access to early prenatal care.	X	X	X	X
6. Support fetal and infant mortality review processes in every jurisdiction to promote perinatal systems improvements.				X
7. Assess and monitor trends in the use of prenatal care.				X
8. Support perinatal educational events and conferences to educate providers, families and the general public about best practices in improving birth outcomes. t			X	
9. Continue Medicaid and MCHP coverage of prenatal care services for pregnant women with incomes upto 250% of the federal poverty level.		X		
10.				

#### **b. Current Activities**

The Babies Born Healthy Initiative provides a comprehensive approach to reducing risks that improve perinatal health. In late 2007, Babies Born Healthy partnered with Maryland Medicaid to enhance its Healthy Start program. The Medicaid's Healthy Start program provides care coordination for pregnant and postpartum women. A software package was purchased to enhance the surveillance capabilities through tracking enabling services received and perinatal health outcomes. The data tracking system will allow for better case management, as well as realization of best and promising practices within Maryland.

Additionally, in collaboration with the Annie E. Casey Foundation, the Governor's Office for Children and others, another important needs assessment and action development occurred through Baby LAP (Leadership in Action Program). Baby LAP is a coalition of providers and advocates, who assess needs and promising practices for perinatal health. This initiative brings together key stakeholders to prioritize and coordinate strategies for infant mortality reduction in Baltimore City. Baby LAP has developed an action plan to reduce infant mortality that is focused on five impact areas. These impact areas include reducing unintended pregnancies; providing support to women who have had a previous pregnancy loss or poor birth outcome; decreasing the number of women who enter pregnancy with poor health; decreasing barriers to early prenatal care; and decreasing infant sleep related deaths.

#### **c. Plan for the Coming Year**

The MCH Program will continue to monitor access to prenatal care services in light of increasing concerns about the trend toward fewer women receiving early prenatal care services overall and variability by jurisdiction. Access to prenatal care was a priority concern identified by the 2005 needs assessment, as well as the planning group for the Early Childhood Health Plan. PRAMS and Vital Statistics data will be used in 2008 to complete a demographic analysis of trends in early prenatal care use rates. In addition, Baby LAP will look to implement initiatives to decrease barriers to accessing early prenatal care. Baby LAP will also work closely with the Baltimore City Health Department as they develop programs and initiatives to support the identified impact areas.

The Babies Born Healthy will continue to provide a comprehensive approach to reducing risks that improve perinatal health. These activities include expanding the University of Maryland's Maryland Advanced Perinatal System Support program to include a preconception and family

planning component, continuing the MCH-WIC Collaborative and improving access to reproductive health services. In addition, the CMCH will reconvene the Perinatal Clinical Advisory Committee to review and update the Perinatal System Standards. These Standards are used to designate perinatal centers in the State of Maryland by the Maryland Institute of Emergency Medical Services Systems. The Title V Program will continue to partner with several agencies and organizations that promote early prenatal care including the March of Dimes, local health departments and State Medical Professional associations.

## D. State Performance Measures

### State Performance Measure 1: *Percent of pregnancies that are intended*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				58.9	60
Annual Indicator	58.8	58.8	57.0	59.7	59.7
Numerator	44020	43806	42682	46226	46226
Denominator	74865	74500	74880	77430	77430
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	60	60	60.5	60.5	60.5

#### Notes - 2007

Source: Estimate based on findings from the 2006 PRAMS report. Data for 2007 is unavailable.

#### Notes - 2006

Source: 2006 Maryland PRAMS Report, page 7.

#### Notes - 2005

Source: PRAMS Report for 2003, 58.8% pregnancies were identified as intended. Data is 2005 is currently unavailable. There are no data on the number of pregnancies; number of births is used as a proxy.

#### a. Last Year's Accomplishments

intendedness. In 2006, there was an increase in intended pregnancies from 57.0% in 2005 to 59.7% in 2006. The U.S. Healthy People 2010 goal is for no less than 70% of pregnancies to be intended.

In 2007, the PRAMS Program published an issue brief on unintended pregnancy. Over 40% of pregnancies in Maryland that end in a live birth are unintended. This Brief defined unintended pregnancies as those that are either mistimed (31% in 2001-2005) or unwanted (11% in 2001-2005). However, the Brief notes that there striking differences between women who report that their pregnancies were mistimed versus unwanted. Women with unwanted pregnancies as compared to those with mistimed or intended pregnancies were more likely to smoke, experience postpartum depression and to be a victim of physical abuse. As compared to women with intended and mistimed pregnancies, those with unwanted pregnancies were least likely to take a multivitamin, seek early prenatal care, breastfeed or place their babies on their backs to sleep. African American women, adolescents and women with less than a high school education are more likely than their counterparts to report having an unintended pregnancy according to the Maryland PRAMS survey.

The Title X Maryland Family Planning provides subsidized family planning, preconception health,

teen pregnancy prevention and colposcopy services to women and families in every jurisdiction in the State. The Program serves approximately 70,000 clients annually. Adolescents represent one third of persons served.

Preconception health activities included the WELL Program, a pilot project that expands family planning services to include preventive health services for women of childbearing age. The Babies Born Healthy, MCH/WIC Collaborative provided multivitamins (which includes folic acid) to clients referred from WIC to Family Planning Clinics in three Maryland counties.

The Medicaid Program provides coverage for family planning services to enrollees. In addition, a federal waiver allows the Program to continue coverage for women who are no longer eligible for Medicaid following pregnancy. Eligible women may receive comprehensive family planning and reproductive health services including contraceptives. However, few eligible, less than one in three, are receiving services according to Medicaid claims files. Family planning program staff in several jurisdictions, including Baltimore City indicate that many women are still not aware of their eligibility for Medicaid waiver services. This continues to serve as a barrier to care.

Pregnancy intendedness was addressed in two new initiatives, Babies Born Healthy and the Early Childhood Health Plan. Both initiatives promoted strategies to improve access to family planning and preconception health services. Babies Born Healthy is a response to a worsening in the State's perinatal health indicators. This Initiative expanded access to preconception care, prenatal care and postpartum family services for uninsured and uninsurable pregnant women in local health departments and other safety net provider sites.

PRAMS data shows a decrease in unintended pregnancy in teens from over 80% in 2005 to 75.8% in 2006. Teen pregnancy prevention efforts are discussed under national performance measure #8.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund family planning and reproductive health clinical services to promote access to care in every jurisdiction of the State	X			
2. Distribute family planning brochures to all residents requesting a marriage license. Develop a preconception health brochure that promotes the use of folic acid and promotes other healthy habits to persons planning to marry.				X
3. Analyze and disseminate PRAMS data on pregnancy intendedness in Maryland.				X
4. Refer Marylanders to family planning services through the MCH Hotline.		X		
5. Continually update and disseminate family planning program administrative guidelines.				X
6. Identify and implement strategies to reduce teen and unintended pregnancies. Administer federal abstinence education funding.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

This year, CMCH completed an application for a three-year (July 1, 2008 -- June 30, 2011) Title X Family Planning Supplemental Expansion grant to expand family planning clinical service delivery. The purpose of this grant is to provide additional clinical services to populations in need - particularly low-income individuals, teens and Hispanics - through strategies that include increasing the capacity of current providers, adding new service providers, linking with other community-based entities, and employing clinic efficiency strategies to enhance the ability to serve additional clients.

Reproductive health services will be targeted to low income clients, with a focus on teen and Hispanic clients, in the Prince George's/Montgomery County areas, and will provide Title X services to an additional 2,500-3,000 clients in need of subsidized reproductive health care after the first project year. Service delivery partners will include a federally qualified health center and the WIC Program.

### c. Plan for the Coming Year

Ongoing activities will continue in FY 2009. The Family Planning Program will continue to operate in 2009. The MCH Program has prepared a budget initiative seeking additional funding for family planning services. According the Guttmacher Institute, the Program is currently only able to serve less than half of the 200,000 Maryland women estimated to be in need of subsidized family planning services.

At the writing of this application, the availability of continued federal funding for abstinence education is uncertain. The Program is currently considering options for addressing unintended pregnancies among teens during the coming year in light of this situation.

### State Performance Measure 2: *Percent of women reporting alcohol use in the last three months of pregnancy*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				9.8	9.7
Annual Indicator	9.9	7.2	6.5	7.2	7.2
Numerator	7412	5364	4867	5575	5575
Denominator	74865	74500	74880	77430	77430
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	7	7	6.5	6.5	6.5

#### Notes - 2007

Source: Estimate based on results in the 2006 Maryland PRAMS Report. Data for 2007 is currently unavailable.

#### Notes - 2006

Source: 2006 Maryland PRAMS Report, p. 41.

#### Notes - 2005

Source: Numerator: 2003 Maryland PRAMS Report, 9.9% of women reported drinking during last three months of pregnancy. Data is currently unavailable for 2005.

Denominator refers to number of live births in 2004.

#### **a. Last Year's Accomplishments**

Prenatal alcohol exposure is the leading known cause of mental retardation. Alcohol exposure at any point during fetal development may cause permanent, lifelong disabilities. Fetal Alcohol Spectrum Disorder (FASD), the term given to disorders caused by prenatal alcohol exposure, was identified as an emerging priority during the 2005 Title V needs assessment. It is estimated that between 700 to 750 new cases of FASD occur in Maryland each year.

PRAMS data for 2006 indicate that too many Maryland women are continuing to drink during the last three months of pregnancy (7.5%). A smaller percentage (< 1%) reported a binge drinking episode during the last three months of pregnancy. Alcohol use rates were highest for White women, women over the age of 35, and women with a more than a high school education. Local health department staff (particularly those in rural areas) surveyed for the Title V needs assessment indicated that they were seeing increasing evidence of alcohol addiction among pregnant women and women of childbearing age.

In 2006, a statewide FASD Coalition was formed. The Coalition includes representatives from State agencies (e.g., Education, Juvenile Services, Disabilities), DHMH agencies (e.g., Mental Health, Medicaid), universities and community groups. CMCH provides leadership and staffing for the Coalition and appointed a State FASD Coordinator in 2006. One major Coalition goal is to develop a long range plan for increasing awareness of FASD among all sectors -- health care, substance abuse treatment, social services, education, juvenile services, the faith community, business and industry as well as families and individuals. The Coalition has developed Work Groups to accomplish its tasks. Educational materials (e.g., posters, brochures) and a website have been developed for a public information campaign as mandated by Legislation passed in 2006.

CMCH and the FASD Coalition held the State's first FASD conference in September 2007. The conference featured both local and national experts and was geared towards professionals serving families affected by FASD. Over 150 professionals attended. The FASD Coordinator also collaborated with the Early Childhood Health Team to develop and implement a CME unit to increase provider awareness of the need to screen patients to prevent and/or address FASD. The target group for training is psychiatrists, psychologists, OB/GYNs, and pediatricians.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Provide administrative and staff support for a statewide coalition to address Fetal Alcohol Spectrum Disorders (FASD).				X
2. Implement a State mandated outreach and education program to raise awareness about FASD. Develop and disseminate outreach materials			X	
3. Develop and maintain a FASD website.				X
4. Hold a statewide FASD conference to educate providers and other stakeholders about FASD.				X
5. Analyze data and publish issue briefs and reports on the problem of FASD in Maryland.				X
6.				
7.				
8.				
9.				
10.				

### **b. Current Activities**

Activities this year have focused on continuing to promote awareness of FASD to professionals, women, teens and the general public. First, the FASD Coalition and its sub-committees are developing a web based FASD toolkit as a resource for women of childbearing age. The availability of the Toolkit will be promoted through placement in physician offices, local health departments and on college/university campuses. Secondly, the Coalition is sponsoring an educational meeting for professionals and service providers, entitled "An Evening with Kathy Mitchell." Ms. Mitchell is the Director of the National Organization for Fetal Alcohol Syndrome. She will discuss the effects of FASD on children and families and will offer guidance on working with women to prevent this disorder. Thirdly, the State Coordinator along with other committee members has been working with the Girls Scouts of Central Maryland to develop a Service Project to promote awareness of FASD among adolescent girls. Finally, a FASD poster contest targeted to middle and high school students is being planned. Winning entries will be included in a 2009 FASD calendar.

### **c. Plan for the Coming Year**

In the coming year, CMCH along with the FASD Coalition will focus on:

- . Finalizing and widely disseminating a comprehensive five year action plan for prevention of FASD and improving the system of care families and individuals affected by FASD.
- . Continuing a five year public information campaign based on recommendations in the FASD plan.
- . Continuing to conduct continuing education seminars on FASD for physicians, health educators, school health personnel, foster care workers and juvenile justice staff.
- . Organizing and hosting a 2nd statewide FASD conference.
- . Analyzing available data on alcohol use during pregnancy.
- . Identifying funding to sustain activities.

### **State Performance Measure 3: *Percent of Maryland kindergartners entering school ready to learn***

#### **Tracking Performance Measures**

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				61	67
Annual Indicator		58.0	60.0	67.0	67.0
Numerator		26086	31889	37609	37609
Denominator		44975	53148	56133	56133
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	68	69	70	71	72

#### **Notes - 2007**

The Maryland Model for School Readiness (MMSR) defines early learning standards and indicators of what children should know and are able to do before they start formal education. The MMSR includes as its assessment component the Work Sampling System™ (WSS), a portfolio-based assessment system that helps teachers to document and evaluate children's skills, knowledge, behavior, and academic accomplishments across a variety of curricular areas. This is done by ongoing observation, recording, and evaluation of daily classroom experiences and activities that help teachers to gain a better understanding of what students know, are able to do, and areas requiring more work. The seven WSS™ learning domains are:

1. Social and Personal Development;
2. Language and Literacy;

3. Mathematical Thinking;
4. Scientific Thinking;
5. Social Studies;
6. The Arts;
7. Physical Development and Health.

#### **Notes - 2006**

Source: MD School Readiness Report.

#### **Notes - 2005**

Source: Maryland State Department of Education

#### **a. Last Year's Accomplishments**

At the beginning of each school year, Maryland kindergarten teachers assess the school readiness skills of incoming students. These data are used to track progress in school readiness and to help teachers revise their curriculum to meet the needs of all kindergarten children. In the 2007-2008 school year, 68% of Maryland kindergartners entered school fully ready to learn, a substantial overall jump from 49 percent in the 2001-2002 school year. However, significant gaps in school readiness remain between the children most in need (e.g., poor children, children with limited English proficiency and those lacking high-quality learning environments) as compared to their counterparts.

During 2007, Maryland completed its second year of implementation of the ECCS State Plan Growing Healthy Children. The Early Childhood Health Administrator, along with an Advisory Group of stakeholders, oversaw implementation of several strategies including:

- . Training child care health consultants to work with child care centers. This pilot project involved local health department nurses in providing support and training on a myriad of early childhood health issues to licensed child care providers.
- . Improving developmental screening in pediatric practices in Maryland, in partnership with the Maryland Chapter of AAP, and the Office for Genetics and Children with Special Health Care Needs. This continuing project involves supporting physician training by developing and promoting developmental screening and measurement tools, conducting grand rounds and providing a developmental forum for providers.
- . Working with two rural local health departments to implement a model program developed in Boston - Reach Out and Read. This model program purchases and distributes age appropriate children's books through provider offices and in Maryland will include the introduction of these books to parents in households where Spanish is the primary language.
- . Raising provider awareness of the importance of preconception health. A CME has been developed as well as materials that promote preconception health (based on newly released CDC guidelines). A priority focus is on increasing provider awareness of screening to prevent and/or address FASD. The CME link can be accessed on State and provider websites. The target groups for the educational sessions include psychiatrists, psychologist and pediatricians.

Partnership building and collaboration continued through CMCH representation on several inter-agency committees and work groups addressing early childhood health and school readiness issues. These include the Early Childhood Mental Health Steering Committee and the State's Early Care and Education Committee. The Early Childhood Mental Health Steering Committee is charged to develop a plan for integrating mental health services into existing early childhood programs. Two major achievements of this Committee in 2007 were 1) the receipt of increased funding for early childhood mental health service and 2) the development of a certificate program in early childhood mental health that trains master's level mental health professionals to provide early childhood mental health consultation in licensed early childhood programs.

Prevention of childhood lead poisoning continued as an important early childhood health activity

within CMCH. Maryland has developed an inter-departmental plan with the goal of eliminating new cases of childhood lead poisoning by 2010. CMCH administers the Childhood Lead Screening Program and works in partnership with the Maryland Department of the Environment (the lead State agency for lead) to reduce childhood lead poisoning. Title V funds supported lead activities in Baltimore City and outreach and education activities of the Coalition to End Childhood Lead Poisoning. CMCH continued to oversee development and implementation of a legislatively mandated targeting plan for identifying areas at greatest risk for lead problems. Children in these areas are required to be screened for lead with a blood test at ages 12 and 24 months.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement the State's Early Childhood Health Plan				X
2. Hold a statewide Early Childhood Health Conference				X
3. Train regional child health consultants to work with child care programs				X
4. Promote preconception health guidelines issued by the CDC.				X
5. Develop and distribute materials to increase provider awareness of FASD and maternal depression. Partner with the Mental Health Association to promote awareness of perinatal depression.				X
6. Assess the oral health needs of low income children enrolled in the Head Start Program.				X
7. Represent DHMH on interagency groups focused on improving school readiness.				X
8.				
9.				
10.				

#### **b. Current Activities**

This year, Maryland also saw an opportunity to improve the wellness of young children by applying for funding through a new federal SAMSHA initiative, Project LAUNCH. CMCH has partnered with the Mental Hygiene Administration seek these funds to enhance the State's early childhood mental health infrastructure. If funded, the grant will allow the State to create a seamless system of care for young children and their parents/caregivers through the development of a local infrastructure in the targeted community of Baltimore City that incorporates quality and accessible health, mental health, behavioral health and socio-emotional services.

The Early Childhood Administrator continues to represent CMCH on numerous inter-agency groups addressing early childhood issues and works closely with the Maryland Department of Education (including Head Start, the Office of Child Care), the Governor's Office of Children, the Mental Hygiene Administration and the Maryland Department of the Environment (lead poisoning prevention).

#### **c. Plan for the Coming Year**

Maryland will enter its third year of implementation of the ECCS State Plan: Growing Healthy Children in 2009. During the Federal Partners Meeting held this past spring (2008), Maryland was given guidance to chose two priority focus areas for 2009. Early childhood mental health and family support were the two main focus areas chosen by Maryland stakeholders. To address

these priority areas, the Early Childhood Health Administrator, along with an Advisory Group of stakeholders, is planning to continue many of the strategies identified above as well as to implement several new ones. These strategies will focus on:

- . Improving coordination and infrastructure building at the local levels;
- . Developing innovative ways to increase physician involvement in school readiness and early childhood health efforts;
- . Promoting Babies Born Healthy, the State's initiative to improve pregnancy and birth outcomes;
- . Increasing access to family and parent support programs; and
- . Continuing support early childhood mental health efforts in early childhood settings.

The priority areas will also be a major foci of the Early Childhood Health Summit being planned for this fall. Stakeholders from across the State will be invited to attend to learn about State progress on improving early childhood health as well as remaining challenges to further progress.

CMCH is also a key partner in the planning of a Healthy Homes Festival to coincide with the National Healthy Homes conference to be held in Baltimore from September 15th to the 18th of this year. The Festival will promote the importance of the healthy homes approach to prevent lead poisoning, asthma, injuries and other environmentally health concerns

**State Performance Measure 4:** *Rate of emergency department visits for asthma per 10,000 children, ages 0-4*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				170	200
Annual Indicator	181.6	186.1	203.1	221.9	221.9
Numerator	6619	6783	7749	8171	8171
Denominator	364507	364507	381487	368199	368199
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	220	220	218	218	218

**Notes - 2007**

Source: MD Health Care Commission Reports for 2006.

**Notes - 2006**

Source: MD Health Care Commission Reports for 2006.

**Notes - 2005**

Source: Maryland Health Care Commission Database

**a. Last Year's Accomplishments**

Statewide, about 13.3% of Maryland adults and 13.1% of children have a history of asthma. About 8.7% of adults and 9.2% of children currently have asthma. Emergency department (ED) visits, hospitalizations and mortality suggest a failure to manage asthma properly. Children under the age of five have the highest ED visit of any age group in Maryland. While the Healthy People 2010 goal is for is 80 visits per 10,000 population, Maryland's youngest children had 222 visits per 10,000 in 2006.

The Maryland Asthma Control Program or MACP addresses both pediatric and adult asthma and is administratively housed in CMCH. The Maryland Legislature mandated establishment of the

MACP in 2002 and charged the Program to develop a statewide asthma surveillance system and an asthma control program. Maryland has received a CDC asthma grant since 2001 that supports staff salaries (i.e., an asthma epidemiologist and an administrator) and funds sub-grantees. Title V partially supports the costs of administrative staff, program printing and the purchase of educational materials.

MACP continued to implement select interventions to reduce asthma morbidity and mortality in 2007. The third edition of the Asthma Surveillance Report was completed. Chapters were added to address work-related asthma, asthma among Medicaid enrollees, and racial/ethnic disparities in asthma morbidity and mortality. The Program maintains a Website that includes a Maryland Asthma Resource Guide that was published in 2005 and is currently being updated. Asthma in Maryland, 2005, the most recent asthma surveillance report, is available at [www.marylandasthmacontrol.org](http://www.marylandasthmacontrol.org).

The Maryland Asthma Coalition partnered with the Greater Baltimore Asthma Alliance to celebrate Asthma Awareness Month. An Asthma Action Plan has been developed for use by families and providers to ensure that appropriate actions are taken to control asthma. Health care provider professional organizations developed and implemented educational activities to improve adherence to NHLBI Guidelines.

Asthma continues to disproportionately affect African American children in Maryland, particularly those living in Baltimore City. Title V funding to the Baltimore City Health Department supported the Childhood Asthma Program. This Program provides outreach, education home based case management to families of young children (ages < 6) affected by asthma. Parents/caregivers are educated about the importance of eliminating environmental triggers and proper asthma medical management.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Maryland Asthma Control Program.				X
2. Continue asthma surveillance activities including annual publication of surveillance reports and briefs.				X
3. Revise the State's Asthma Control Plan. Refine and implement a statewide plan to address disparities in asthma outcomes.				X
4. Fund local health department based asthma interventions including support for local and regional asthma coalitions.				X
5. Co-chair and provide staff support for the Maryland Asthma Coalition.				X
6. Provide staff support for the Children's Environmental Health Advisory Council. Disseminate the Children's Environmental Health Indicators Report prepared by the Council and which includes asthma data.				X
7. Collaborate with State and local healthy homes initiatives				X
8.				
9.				
10.				

**b. Current Activities**

In 2008, Dr. Cheryl DePinto, Medical Director for Child and Adolescent Health, was appointed as the Principal Investigator for the CDC asthma grant. She co-chairs (with the American Lung Association) the Maryland Asthma Coalition and chairs the Executive Committee, an advisory

arm to MACP and the Coalition.

Health promotion activities continue to build awareness and educate families about proper asthma management. Plans are in place to update the current Asthma Action Plan to include information from the revised NIH Asthma Guidelines. A toolkit entitled "Asthma in the Older Adult: Tools to Better Health" was created to educate care givers and providers regarding asthma in adults over 65 years old.

Grants to selected local health departments in 2008 support coalition building on the lower Eastern Shore; and asthma education and awareness programs in Howard, Garrett, Wicomico and Charles counties. A Montgomery County project is working with low-income Latino parents to increase knowledge about proper asthma treatment and management. A grant to the Coalition to End Childhood Lead Poisoning, a group that is now also focusing on broader healthy homes issues such as asthma, is receiving a grant to increase asthma awareness in Baltimore City and Prince Georg's County.

### **c. Plan for the Coming Year**

Proposed asthma activities for 2009 will include:

- . Seeking continuing CDC grant funding for asthma control activities. In August 2008, Maryland will complete its seventh year of CDC asthma grant funding. This funding largely supports largely supports asthma infrastructure activities including surveillance and planning in the State. Since CDC funding is slated to become much more competitive during the 2010 funding cycle, Maryland will be gearing up in 2009 to position itself to become a successful applicant. Activities will include revising the State's asthma control plan, strengthening State and local partnerships and improving data collection and surveillance.

- . Revising the Maryland Asthma Plan to include updated information and feedback from the community regarding proper asthma management and education. The Plan will include updated information from the originally published 2004 Plan while including expanded and more detailed goals and objectives based on input from town hall meetings and focus groups.

- . Maintaining and expanding the asthma surveillance system. MACP anticipates participating in the BRFSS Asthma Call Back Survey. This Survey will provide data on the frequency and severity of asthma episodes, treatment and management practices, environmental controls and exposure, cost, etc. MACP has published four annual comprehensive surveillance reports (2002-2005). With the hiring a new full-time asthma epidemiologist in 2008, the Program plans to expand surveillance resources and begin publishing more timely in-depth issue briefs, fact sheets and special reports in place of a single comprehensive report.

- . Educating providers, parents/patients and the public about asthma prevalence, treatment and best practices management. The University of Maryland Breathmobile will continue to receive support to conduct education and case management for asthmatic children in Baltimore City. Activities and outreach will take place to educate providers and health officials concerning the updated NAEPP Guidelines.

- . Continuing to support and maintain the Maryland Asthma Coalition as well as local coalitions. An Executive Committee to the Coalition has been re-engaged.

- . Promoting healthy environments to lessen the impact of asthma. MACP will continue its partnership with a national coalition to educate child care providers concerning the effects of the indoor environment on asthmatic children. This Healthy Homes approach includes provider trainings, two disparities workshops and numerous educational events throughout Baltimore City and Prince George's county.

- . Participating in planning the National Healthy Homes Meeting scheduled to be held in Baltimore in September 2008.

- . Disseminating the Older Adult Asthma Toolkit.

**State Performance Measure 5:** *Percent of Maryland 12th graders who graduate from high school*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				84.9	86
Annual Indicator	84.7	84.3	84.8	85.4	85.4
Numerator				51800	51800
Denominator				60656	60656
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	86.1	86.2	86.3	86.4	86.4

**Notes - 2007**

Source: Estimate based on Maryland State Department of Education, Maryland Report Card for the 2006/2007 School year.

**Notes - 2006**

Source: Maryland State Department of Education, Maryland Report Card for the 2006/2007 School year.

**Notes - 2005**

Source: Maryland Department of Education. Data for numerator and denominator is not available.

**a. Last Year's Accomplishments**

Adolescence, however it's defined (ages 10 - 19 or 12-19 or 13-21), is a time of tremendous change and growth. This transitional developmental period between childhood and adulthood offers many physical, mental and emotional challenges. Risk taking is the norm during this period. While many adolescents make the transition to adulthood with few problems; others do not fare as well. During the 2005 Title V needs assessment, focus groups with parents and service providers consistently identified the need to promote healthy, positive youth development by offering adolescents "a sense of the future." The health care delivery system was viewed as "unfriendly" to adolescents and ill equipped to address growing mental health, psycho-social and emotional problems of teens. Adolescent health promotion was chosen as an MCH priority to highlight the unique needs and issues that affect this often overlooked segment of the MCH population within the public health system.

Evidence is mounting that school success largely depends on whether students are safe, healthy, and resilient. Positive health status has been linked to many aspects of academic achievement including improved test scores, retention, decreased absenteeism. In Maryland, approximately 85% of high school seniors graduate (2006-2007 school year). Graduation rates varied by race/ethnicity and were lowest for African Americans (78.9%) for the 2006-2007 school year.

CMCH employs a Medical Director for Child and Adolescent Health as well as a State Adolescent Health Coordinator to oversee planning, policy development and program implementation for school and adolescent health. In addition, support for adolescent health is provided by the State's Abstinence Education Coordinator, and a community health educator who oversees teen pregnancy prevention efforts and Family planning program staff who work with teens.

DHMH and the State Department of Education are jointly responsible for developing standards

and guidelines for school health programs and offering assistance to county boards of education and local health departments in implementing these standards and guidelines. CMCH is responsible for promoting the health of school aged children and ensuring that schools comply with mandated school health standards. The Medical Director for School and Adolescent Health continued to provide medical consultation on school and adolescent issues in 2007.

MCH provided several training opportunities in 2007 to promote healthy and positive youth development. The School Health Interdisciplinary Program (SHIP) meeting held in August 2007, provided intensive professional development opportunities to school health and youth serving agency professionals. Several of the 40 training sessions focused on skill building to reduce risky behaviors among adolescents and to promote positive youth development. Abstinence education funds awarded to the University of Maryland School of Social Work supported adolescent focused training and educational events for adolescents and youth serving agencies. During 2007, CMCH continued to collaborate with the Johns Hopkins Bloomberg School of Public Health (JHSPH) on a special project to improve adolescent health. The intent of the "Adolescent Colloquium" is to develop a set of core principles to guide adolescent health promotion and health service activities. A series of three meetings were held in 2006 with representatives from state agencies and community groups. Dr. Robert Blum of the JHSPH presented an overview of the research that supports the concept of youth development and the outcomes that youth development programs can have on the health and well-being of youth. The discussion that followed resulted in a concept paper to help promote youth development within all State and community serving organizations. Participants began developing an action agenda for moving the project forward.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Co-sponsor the annual School Health Interdisciplinary Program (SHIP), a four day institute designed to educate school personnel about a broad range of health and social issues that impact school retention and performance				X
2. Implement strategies to prevent teen pregnancy and improve life chances for students				X
3. Monitor and publish data on adolescent health including assets and risk factors that impact school retention and performance				X
4. Represent DHMH on the Ready by 21 Initiative and other partnerships sponsored by the Governor's Office of Children to promote positive youth development				X
5. Conduct child fatality review processes to identify prevention strategies to protect teens				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The Adolescent Health Colloquium has evolved into an Advisory Board on adolescent health and has developed a Healthy Adolescent Guide to provide guidance to a broad audience including providers, parents, and community based organizations serving youth. It is expected that the guide will provide concepts on various issues that could be lifted out as a resource for specific groups. JHSPH's writer has compiled the information provided by the Colloquium members. The

Adolescent Health Guide has been completed and is currently being reviewed and edited by the Colloquium. It is expected to provide guidance to a broad audience on issues related to optimal adolescent health and well-being.

The Medical Director for School and Adolescent Health continues to represent the MCH Program on the statewide planning initiative, Ready by 21 sponsored by the Governor's Office for Children in 2007. The goal is prepare Maryland children and adolescents to be productive, healthy citizens and prepared for the workforce by the age of 21. Improving high school graduation rates is one of the objectives. A document has been developed and presented to the subcabinet for review.

### c. Plan for the Coming Year

Ongoing activities will continue in FY 2009.

CMCH is also currently taking steps to convene an adolescent health data collaborative to assist in promoting healthy adolescent development in Maryland. This involves pulling together representatives of State agencies involved with adolescent data issues to identify adolescent "hot spots" across the State to support policy and program development. These data would be used to (1) develop and refine adolescent health performance measures for the MCH performance monitoring system and (2) to identify communities most in need of positive youth development activities -- "hot spots," and (3) support the 2010 Title V needs assessment.

The School Health Interagency Program is scheduled for August 4 -7, 2008, at Turf Valley Resort and Conference Center. The title for 2008 is "Charting the Course for Our Children's Future" and includes topics covering the eight components or comprehensive school health. Speaker's topics include the adolescent brain, fetal alcohol spectrum disorder, the role of school health in eliminating health disparities, mental health issues in school health, gangs, school connectedness, youth suicide prevention, early childhood topics, family violence, trauma history and it's effects on school performance, HIV, pharmacology, internet safety, and others.

### **State Performance Measure 6:** *Percentage of local jurisdictions addressing the issue of respite for families of CSHCN*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	75	75	75	75	75
Annual Indicator	70.8	66.7	70.8	66.7	62.5
Numerator	17	16	17	16	
Denominator	24	24	24	24	
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	62.5	62.5	62.5	62.5	62.5

#### **Notes - 2007**

Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

Annual Performance Objectives have been revised based on the most recent data.

#### **Notes - 2006**

Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

## Notes - 2005

Source: Data from OGCSGCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

### a. Last Year's Accomplishments

Respite continues to be a significant need for Maryland families of children and youth with special health care needs (CYSHCN). Respite provides CYSHCN and their families with a break from their daily routine. It is an opportunity for new experiences, building new skills, developing independence and making new friends. For caregivers and families, respite is integral to their well-being. It is what enables them to resume the daily and protracted care of their children. On the 2005-06 National Survey of CSHCN (NS-CSHCN), approximately 5.5% Maryland of families of CYSHCN reported needing respite care, corresponding to an estimated 11,700 families. Of these families, close to half (47.5%) reported an unmet need for respite care.

In FY07, the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) awarded respite funds to 15 of Maryland's 24 local jurisdictions. Funding for respite services through the local health departments decreased by approximately 20% from the previous fiscal year. With continued level funding of the Block Grant and persistent State budget problems, local jurisdictions have been forced to tap into respite monies to cover the cost of living adjustments for their staff providing other services to CYSHCN such as care coordination. In fact, the overall funding for respite has steadily decreased since FY05, with a corresponding decrease in numbers of children and families served (over 30%).

Despite this, local jurisdictions, in collaboration with families and community agencies, continued to have success in developing creative and cost effective respite initiatives. Their efforts provided funding to a total of 556 CYSHCN; 245 received "respite hours" and 311 attended camps. Funding was not limited to any particular special health care need or disability. Diagnoses varied from diabetes, asthma and heart disease to epilepsy, Down Syndrome, and cerebral palsy.

The OGCSHCN also provided funding in FY07 to disease-specific advocacy organizations to support operation of summer camps for CYSHCN. The Maryland Alliance of PKU Families received support for PKU Camp, a family camp which served 82 individuals in FY07. Monies were also awarded to support the operation of Camp New Friends, a camp for children with neurofibromatosis. In FY07, 71 individuals with neurofibromatosis participated in this camp as either campers or counselors.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide grants to local jurisdictions to support a variety of respite care activities		X		
2. Provide grants to disease-specific advocacy organizations to support operation of summer camps for CYSHCN		X		X
3. Serve on Governor's Caregiver Support Coordinating Council				X
4. Refer families to other potential sources of funding for respite care		X		
5.				
6.				
7.				
8.				
9.				
10.				

### b. Current Activities

In FY08, funding for respite services was decreased once again due to budgetary constraints. The OGCSHCN awarded 15 local jurisdictions monies for respite activities.

The OGCSHCN's Regional Resource Development Coordinator, a parent of a child with special health care needs, is the Department of Health and Mental Hygiene's designee on the Governor's Caregiver Support Coordinating Council (GCSCC). The GCSCC has put a significant amount of work into the development of a "Lifespan Respite Model" for the state. This model includes a statewide Lifespan Respite Director who will partner with local lifespan networks to develop a regional/universal application, streamline lifespan resource information, develop a system of "No Wrong Door" access, and assist in coordinating caregiver training efforts. Unfortunately, monies have yet to be appropriated for the federal Lifespan Respite Care Act of 2006 (HR 3248), which could potentially serve as a funding source for Maryland's Lifespan Respite Model.

### c. Plan for the Coming Year

To date, 14 of Maryland's local jurisdictions have been awarded respite funding for FY09. With continued level funding of the Block Grant and the State's persistent budget problems, the OGCSHCN does not anticipate being able to make significant strides in increasing the number of jurisdictions with funding for respite care. The OGCSHCN will continue to work with local health departments to explore mechanisms of partnering and collaborating with other community agencies to expand respite capacity as possible. In addition, the OGCSHCN will continue to refer families of CYSHCN to other sources of respite funding for which they may be eligible including funding through the Developmental Disabilities Administration and the Department of Human Resources.

## State Performance Measure 7: *Percent of mothers breastfeeding at six months*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				42	44
Annual Indicator			40.8	40.8	40.8
Numerator			29085	29085	29085
Denominator			71286	71286	71286
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	46	48	50	50	50

### Notes - 2007

This is no longer a valid state performance measure.

### a. Last Year's Accomplishments

This is no longer a valid state performance measure.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This measure has been retired as a State measure since it became a national measure in 2006.				
2.				

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

This is no longer a valid state performance measure.

**c. Plan for the Coming Year**

This is no longer a valid state performance measure.

**State Performance Measure 8:** *Percent of local jurisdictions with written plans to address racial and ethnic disparities in maternal and child health*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2	10
Annual Indicator			8.3	8.3	8.3
Numerator			2	2	2
Denominator			24	24	24
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	15	15	20	20	20

**Notes - 2007**

Source: Survey of local health department MCH programs.

**Notes - 2005**

Source: Survey of local health departments.

**a. Last Year's Accomplishments**

The 2005 needs assessment identified (1) increasing racial/ethnic diversity within Maryland's population, (2) the existence of persistent and widespread racial and ethnic disparities in maternal and child health, and (3) the urgent need to systematically address these disparities if the health of women, children and families in Maryland is to improve. With few exceptions (e.g., suicide and substance use), African American mothers, babies, children and adolescents fare far worse than other racial/ethnic groups on most measures of mortality, morbidity, health and social status, and access to health care. Twenty of the State's 24 jurisdictions have racial and ethnic minority populations greater than 10%. In 2006, local health departments in at least two jurisdictions had developed written plans or program initiatives for addressing racial and ethnic disparities.

The Maryland General Assembly created the Maryland Office of Minority Health and Health Disparities in 2004. In 2005, MHHD received a five year \$0.8 million Federal Office of Minority Health grant to address racial and ethnic health disparities in Maryland. Several MCH staff members attended the fourth annual statewide health disparities meeting sponsored by the Office of Minority Health and Health Disparities (MHHD). This Office released the State's first plan to eliminate minority health disparities in December 2006. The 2007 conference focused on cultural competency and highlighted the need to diversify the health care workforce and increase the

cultural competency of all health care providers.

Perinatal disparities continued to be addressed under the Babies Born Healthy Initiative initiated with new State funding in 2006. This Program was designed to address recent increases in the State's infant mortality rate as well as known disparities in perinatal outcomes. Strategies included working with Baltimore City Healthy Start, Inc. to assess the need for expanding services to additional high risk areas in Baltimore City.

CMCH was represented on an internal Family Health Administration (FHA) Workgroup charged to develop recommendations for an administration wide approach to addressing health disparities. This Workgroup developed a toolkit for addressing racial and ethnic disparities within FHA.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Survey local health departments to determine activities.				X
2. Participate on committees convened by the Office of Minority Health and Health Disparities to address State health disparities				X
3. Work with the Family Health Administration to develop a strategy to address racial and ethnic disparities in family health programs				X
4. Develop and disseminate issue and policy briefs on MCH disparities				X
5. Develop and implement a plan to address MCH disparities				X
6. Educate local MCH program directors and staff about MCH disparities				X
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Dr. Marsha Smith, the Medical Director for Perinatal Health, is participating in a workgroup to develop a cultural and linguistic competence self-assessment tool for use by Fetal and Infant Mortality Review (FIMR) teams. The members of the workgroup are from Washington, D.C.; Virginia; and Maryland fetal and infant mortality review programs. The development of this self-assessment tool is a new effort supported by collaboration between the National Center for Cultural Competence and the National Fetal and Infant Mortality Review Program. Dr. Smith also has also prepared and given a presentation on "Racial and Ethnic Disparities in Pregnancy Outcomes" before several groups this year as part of the Babies Born Healthy Initiative.

At the request of the OMHHD, CMCH recently completed a plan to address MCH disparities in four areas: adverse birth outcomes, asthma, teen pregnancy and lead poisoning. Strategies include data collection and analysis, participation in collaborative efforts with other agencies and provider groups, and the dissemination of policy briefs and reports. The Plan will be shared with local health departments to encourage similar plan development within their communities.

#### **c. Plan for the Coming Year**

CMCH will continue to address MCH disparities as a priority focus in 2009. A health disparities webpage will be developed for the CMCH Website and an issue brief on MCH disparities will be completed. These activities were planned for last year as well, but limited staffing precluded their completion. CMCH plans to hire a new senior MCH epidemiologist with funding through the SSDI

grant to complete work on disparities.

As part of 2010 needs assessment activities, the MCH Program is planning to review MCH disparities by jurisdiction and to use the results to structure technical assistance to local programs. The MCH Program plans to identify and work with at least two local health departments to strengthen data collection, data analysis and program planning to address MCH disparities. Technical assistance will be sought from the DHMH Office of Health Disparities to develop a model for working with local health department MCH staff to address disparities.

A Babies Born Healthy Summit is being planned for the fall of 2008 to spotlight the problem of infant death in Maryland and related issues such as perinatal disparities. The target audience for this invitation only conference will include legislators, health providers, local health departments, community based groups, consumers, State and local agency staff and other stakeholders.

**State Performance Measure 9:** *Percent of jurisdictions that partner with medical homes to develop and to disseminate resource materials.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				41.6	50
Annual Indicator			33.3	41.7	41.7
Numerator			8	10	10
Denominator			24	24	24
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	58.3	66.6	75	79.2	83.3

**Notes - 2007**

OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

**Notes - 2006**

OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

**Notes - 2005**

Source: OGCSHCN survey of local jurisdictions to collect baseline data. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care provider offices.

**a. Last Year's Accomplishments**

Throughout the 2005 needs assessment, we heard that families of CYSHCN often lack information about available community resources and how to effectively access them. This was true for both health-related resources and family support services. Follow-up data from Maryland families indicated that while doctor's offices are the place where parents most often receive information about their CYSHCN, these offices are not seen as the most effective source of information, and parents would like more information related to both medical and non-medical issues than they are currently receiving. Additional data from Maryland pediatricians confirmed that their offices lack information about important state and local resources, and that pediatricians don't feel like they have the time or personnel to put this together for their practice.

Based on data from the local health departments, at least 16 jurisdictions compiled resource information of some type to be used by families, providers, agency staff, and others. This occurred in many different forms including printed resource guides, web-based information, and 211 warm lines. At least 10 jurisdictions reported sharing their resource materials directly with medical home providers in order to make the information available to families.

Last year, the Baltimore City Health Department (BCHD), with grant support from OGCSHCN, continued "The Medical Homes Project." This project uses lessons learned from the pharmaceutical industry, which has proven itself extremely effective in "getting in the door" at medical sites and sharing its messages and products. The strategy of this project is to successfully engage pediatric primary care practice staff over provided lunches, with the staff of BCHD programs (Baltimore City Infants and Toddlers, Baltimore City Healthy Start, Healthy Families, Maternal and Infant Nursing, Baltimore HealthCare Access, the Childhood Asthma Program, and Child Find) to share information/resources, to make personal contacts, and to identify ways the systems of care can coordinate efforts on behalf of the children that they serve, particularly at-risk children and infants/young children with SHCN. Like the pharmaceutical companies, this effort included distribution of branded "leave-behind" items, such as mouse pads, pens, and post-it notepads, all imprinted with contact information for the above programs in order to foster better communication and more referrals. In FY07, presentations for staff from seven pediatric sites took place. The Project also began to more systematically collect feedback about its presentations and materials in order to refine future efforts.

The OGCSHCN and its partners also developed and shared resource information with medical home providers and their office staff in the context of the ABCD Screening Academy and through the "Extreme Medical Home Makeover" pilot educational program.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support Medical Homes Project to link Baltimore City pediatric primary care practices with Baltimore City Health Department resources for infants/young CYSHCN		X		X
2. Develop and share resource information with medical home providers throughout the state through multiple mechanisms		X		X
3. Appropriately staff and publicize the Children's Resource Line for its intended purpose		X		
4. Actively involve community partners in quality improvement efforts with medical homes through implementation of Community of Care for CYSHCN Learning Collaboratives				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Related to this state performance measure and the data indicated above, Maryland's medical home state plan includes the goal of improving the ability of pediatric health care providers to connect CYSHCN and their families with needed state and local resources. OGCSHCN has recently completed the development of brief (1-3) page resource lists for each jurisdiction that are posted to the web, linked to a map of Maryland's counties. These lists are readily accessible for download by pediatric health care providers in order to share with families. These lists are not

exhaustive, but are meant to be a starting point for families in finding both health-related and family support services for their child. The availability of these lists is being publicized to both providers and families through multiple mechanisms including the Maryland Chapter of the AAP, The Parents' Place of Maryland (PPMD), and local health department staff.

The OGCSHCN has had a "Children's Resource Line" for a number of years that has not been well staffed, publicized or utilized for its intended purpose. This year, the OGCSHCN began staffing this line with its Regional Resource Coordinator, a parent of a child with multiple disabilities and medical needs who has significant expertise with systems of care for CYSHCN. We also took some initial small steps to publicize the availability of this line and are making plans to more heavily publicize it, including mechanisms targeting pediatric health care providers.

### c. Plan for the Coming Year

The ongoing activities described above will continue in the coming year. In addition, The Parents' Place of Maryland (PPMD), in partnership with the OGCSHCN, has been awarded a State Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs from the Maternal and Child Health Bureau. Block grant funded staff from the OGCSHCN are providing critical leadership and staff support to this Project. One of the Project's major goals is to improve access to family-centered, coordinated, comprehensive care for CYSHCN through medical homes that are part of an integrated, community-based system of services. During the Project, a Community of Care (COC) for CYSHCN Learning Collaborative that identifies and engages key community partners in all aspects of the quality improvement process will be designed and implemented. One of the critical lessons learned from our recent experiences with the BCHD Medical Homes Project and The ABCD Screening Academy is the importance of actively involving community partners in quality improvement efforts with medical homes in order to share information/resources, to make personal contacts, and to identify needed areas of quality improvement in the ways the systems of care can communicate and coordinate efforts on behalf of the children that they serve. In the coming year, development of the COC Learning Collaborative curriculum and recruitment/selection of community teams will occur.

### State Performance Measure 10: *Number of policy or issue briefs developed by the Title V program*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				3	1
Annual Indicator				3	3
Numerator				3	3
Denominator	1	1	1	1	1
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1	1	1	1	1

#### Notes - 2005

Source: Center for Maternal and Child Health Database.

### a. Last Year's Accomplishments

During 2007, the MCH Program made progress in improving its ability to analyze and translate data through issue/policy briefs and reports. A new MCH epidemiologist was hired and immediately began working to improve the Program's ability to acquire and analyze data electronically.

In 2007, the PRAMS Program published results from surveys conducted in 2004 and 2005. The completion of this data analysis phase allowed for five year trends to be developed. Additionally,

PRAMS published two additional issue briefs, one on unintended pregnancy and a second on alcohol use during pregnancy. These publications are available on the CMCH Web Site (<http://www.fha.state.md.us/mch/prams/html/report.cfm>) and have been distributed at MCH stakeholders meetings and at specific perinatal health meetings.

The Center for Maternal and Child Health also published two additional policy/issue briefs during 2007. The first was "Ensuring Healthy Babies in Maryland: A Center for Maternal and Child Health Approach." The purpose of this Issue Brief is to educate policy makers, public health professionals, and the informed public about the state of perinatal health in Maryland, including infant mortality rates, populations at risk, causes of infant death, and risk behaviors. Additionally, CMCH published an issue brief entitled, "Teen Pregnancy Prevention in Maryland." This brief educates stakeholders about trends in teen birth rates, best and promising practices for teen pregnancy prevention, and CMCH activities.

CMCH participated in the preparation of a children's environmental health report, titled 'Maryland's Children and the Environment: Indicators of Contaminants, Body Burdens, and Illnesses'. Staff from the Center provided data and descriptive analysis for this report, which serves as a baseline for documenting the effect of environmental factors on children's health.

In addition, CMCH published the "Child Death Report 2005," documenting the numbers and types of deaths that occurred among Maryland's infants and children. Analyses of racial and jurisdictional disparities were included. This report is an important tool used by the State's Child Fatality Review teams. The State's third Asthma Surveillance Report, Asthma in Maryland 2006, was also published.

A list of current reports and issue briefs is attached to this section.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and disseminate MCH policy or issue briefs based on surveillance data, qualitative analyses, analysis of secondary data sources and/or literature review of evidence based interventions.				X
2. Develop and disseminate a Title V Performance Measure Databook.				X
3. Develop and disseminate a Title X Performance Measure Databook.				X
4. Expand analyses of the PRAMS and Asthma surveillance systems.				X
5. Develop and disseminate reports of State and local FIMR findings.				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

In 2008, PRAMS published the results from the survey conducted in 2006. In addition, there were three focus briefs released. The first described the quality of prenatal care, while the second provided information on male circumcisions. The third brief was focused on HIV counseling and testing.

An updated 'Women's Health Databook' will be published by CMCH in late summer. This report documents that state of women's health in Maryland, including topics on rates of preventive screenings, chronic disease, and causes of death. It is intended to guide policy decisions, as well as to inform the public about women's health issues. CMCH computed the Perinatal Periods of Risk (PPOR) for several jurisdictions, and combined this information with data on racial and ethnic disparities to create presentations for the local health departments to enable them to create strategies to reduce fetal and infant mortality.

CMCH worked with the Maryland Department of the Environment and others to update the 'Maryland Plan to Eliminate Childhood Lead Poisoning by 2010'. This report documents policies and actions that will be implemented to reduce lead poisoning. Two asthma factsheets, one on asthma prevalence and a second on asthma hospitalizations were also completed.

CMCH staff presented a poster on the use of family planning preconception services at the 2007 MCH Epi Conference. Finally, CMCH partnered with the STD Division to develop new policies for the prevention of congenital syphilis.

### **c. Plan for the Coming Year**

The 2010 Title V Needs Assessment will be a major focus for the Maryland Title V Program beginning in FY 2009. Preliminary steps have already been taken to begin the process. CMCH begun work on the 2010 MCH Needs Assessment by reviewing MCHB Reports as well as needs assessment logic models and processes followed by other states. Meetings were held with staff from CMCH and the Office of Genetics and Children with Special Health Care Needs to preliminarily review available data sources as well as data gaps. Assessment activities that are ongoing or already completed were documented. Initial meetings were also held with representatives of other offices within the Family Health Administration to identify data sources of potential use to the needs assessment.

In FY 2008, an Advisory Committee was convened and included representatives from various DHMH offices (e.g., Medicaid, Mental Health); the Maryland State Department of Education; the Maryland Health Care Commission; and local health departments. An initial meeting of the advisory committee was held to review the assessment process. The committee recommended that the Needs Assessment be organized using a combination of a population based and issue driven framework. Meetings of the Advisory Committee will resume in the early fall.

During 2009, the MCH Program also plans to:

- . Develop and disseminate additional issue briefs based on analysis of data in PRAMS, including the topic areas of Hispanic births, smoking, breastfeeding, and initiation of prenatal care. In 2009, sufficient data will be available to permit analysis of changes in responses averaged over two consecutive three year periods.
- . Release the next Child Death Report in early 2009 to include a review of infant and child deaths occurring in 2006.
- . Complete work and release a final report describing the incidence of obesity among children enrolled in Medicaid's Healthy Kids (EPSDT) program. The report will also detail whether these children are receiving appropriate screening for chronic conditions related to obesity.
- . Continue to develop and disseminate Title V and Title X Performance Measures Reports that include trend data and analyses; and
- . Continue work on implementing the State's SSDI plan as described in the 2009 application including the hiring of an MCH epidemiologist to lead MCH data and needs assessment activities.

## **E. Health Status Indicators**

Health status indicator data is collected from several sources including Vital Statistics, the Injury and Sexually Transmitted Infections surveillance systems, and State program databases. Form 21 provides important data on the socio-demographic and socio-economic characteristics of children in Maryland. Social factors are important determinants of health. These data are used to monitor trends in social factors that may have either a negative or positive effect on the health of Maryland children. The data are distributed to MCH staff at the State and local levels to assist with program planning and policy development.

## **F. Other Program Activities**

MCH Hotline/Children's Resource Line: The MCH/Medicaid Programs operate an 800 number telephone line for MCH outreach, information and referral (1-800-456-8900). This line is located and operated by the Medical Assistance Program and is used to provide information and education about the Medical Assistance Program as well as to refer callers to MCH providers.

***//2009/ The Title V Program continues to support the MCH Hotline. //2009//***

Web Sites: Both the Center for Maternal and Child Health ([www.fha.state.md.us/mch](http://www.fha.state.md.us/mch)) and the Office for Genetics and Children with Special Health Care Needs [www.fha.state.md.us/genetics](http://www.fha.state.md.us/genetics)) provide functional Websites. These web sites include information about all programs funded or provided, as well as information about the Title V program, including linkage to a copy of the complete Title V report for the most recent fiscal year.

Child Abuse and Neglect: The Legislature charged DHMH to establish a Child Abuse and Neglect Center of Excellence Initiative within DHMH. Responsibility for administering this Initiative was placed within CMCH. The Center of Excellence trains providers in each region of the State to diagnose and treat child abuse and neglect. Legislation passed in 2006 establishes the Children's Trust Fund under DHMH to fund the Child Abuse and Neglect Centers of Excellence using funds derived from the sale of commemorative birth certificates. CMCH is revised and updated the Commemorative Birth Certificate brochure in 2007 and will soon begin promoting the Children's Trust Fund.

Folic Acid: Legislation passed in 2006 creates a Folic Acid Supplement Distribution Program within DHMH to reduce the number of cases of neural tube defects and other birth defects in Maryland children. No funding was allocated for this fiscal year, but the expectation is that funding will be made available in the next fiscal year. The Program will be housed in CMCH and will work with the Folic Acid Council. Once operational, the Program will distribute a folic acid supplement to women of childbearing age enrolled in the State's Family Planning Program. The Program must also provide counseling and written information regarding the proper use of the supplement.

***//2009/ Funding for this Initiative has not been allocated.//2009//***

Emergency Preparedness: Emergency preparedness is a priority concern for DHMH. DHMH recently consolidated the Office of Public Health Response and the Office of Emergency Response into a single unit reporting directly to the Deputy Secretary for Public Health. This was done to ensure that activities are coordinated. CMCH has also begun to prepare for a range of emergency situations that would benefit from a coordinated MCH approach. A CMCH protocol has been developed and staff are continuing to meet to discuss the role of MCH within the DHMH emergency preparedness program.

Conferences and Training: The MCH Program recognizes the importance of enhancing public

health competency through ongoing training and education. It achieves this activity by providing training opportunities to LHD public health personnel in important MCH domains such as home visiting, school and adolescent health, screenings and surveillance and asthma education. Several conferences are annually supported by the MCH Program. These include the annual reproductive health update, the annual school health institute, an asthma summit, a perinatal health conference, and technical assistance workshops for local health departments. Conferences that address early childhood health as well as Fetal Alcohol Spectrum Disorders are planned for FY 2008.

***/2009/ An MCH/Infant Mortality (Babies Born Healthy) Summit is scheduled for October 2008. //2009//***

Women's Health: An Office of Women's Health was established within CMCH in 2001 with the goal of promoting wellness for Maryland women throughout the lifespan. Activities of this Office include the publication and dissemination of reports (e.g., chartbook on the health status of Maryland women; postpartum depression); promotion of inter and intra-agency coordination on women's health issues, and implementation of a statewide model for integrating preventive health screening into family planning programs. CMCH hosted the annual Women's Health Steering Committee meeting in May 2007. Findings from PRAMS reports for 2004 and 2005 were highlighted.

Sudden Infant Death Syndrome: Title V monies will continue to support the Maryland SIDS Project at the Center for Infant and Child Loss, University of Maryland School of Medicine. This Center provides SIDS outreach and education as well as counseling to support families experiencing the death of a child.

Environmental Health Tracking System: The Community Health Administration continued to work with the Environmental Public Health Tracking Program's network implementation grant from the CDC. The Family Health Administration, including CMCH, will be involved in grant development. The grant references the need for collaboration with a variety of data sources important to Title V including the birth defects registry, hospital discharge data, vital statistics and the childhood lead registry. CMCH has lead responsibility for the Children's Environmental Health Advisory Council and worked to complete a Children's Environmental Health Indicator Report.

***/2009/ The OGCSHCN is working with the Environmental Public Health Tracking Program' to post data on birth defects for public uses on the web as per the CDC protocol.//2009//***

Autism Spectrum Disorders: During the 2005 session, legislation was passed requiring the Maryland Dept of Education, in collaboration with the Maryland Dept of Health and Mental Hygiene, to establish a pilot program to study and improve screening practices for Autism Spectrum Disorders. OGCSHCN sits on the Advisory Council overseeing the implementation of this legislation. A qualified research organization will be awarded a contract to conduct the pilot program this year. OGCSHCN is also funding Baltimore City to pilot a quality improvement initiative for developmental screening in 2 pediatric practices.

## **G. Technical Assistance**

The state of Maryland is not submitting a technical assistance request at this time. Technical assistance needs may be discussed at the August review meeting with the Maternal and Child Health Bureau.

## V. Budget Narrative

### A. Expenditures

This section describes Title V expenditures for FY 2006 and notes trends and shifts in expenditures over the past several years. During FFY 2006, the majority of the \$21,643,799 in Title V -- State partnership funds supported activities at the infrastructure and enabling levels (\$17,201,196 or 79%). These expenditures met the 30-30-10 budgeting requirement.

***//2009/ Maryland continues to meet the 30-30-10 budgeting requirement. During FFY 2007, the majority (78.9%) of funds continued to be used to support activities at the infrastructure and enabling levels. //2009//***

Several significant changes have occurred during the time period 1996-2006. First, the State of Maryland through the development of a fiscal data system has been able to monitor expenditures more effectively and efficiently. This has resulted in the expenditure of all funds during the first year of each grant cycle. Therefore, the Federal-State Title V Block Grant Partnership Total is more reflective of the actual dollars awarded and expended in the first year. This change began in FY 1998 and continues. In addition, beginning in FY 2000 the fiscal data system was refined to monitor more effectively funds within the pyramid itself. Periodically, additional refinements have been made to the system. The most recent one occurred in FY 2006 and resulted in greater accuracy in identifying both State and federal fiscal year expenditures.

The first notable shift in funding allocation occurs in FY 1999 with the advent of MCHP making children in families with incomes up to 200% FPL eligible for Medicaid services. Direct expenditures went from 61% to 28% in one year. This continues to decrease as Maryland's Medical Assistance Program assumes greater fiscal role, including covering more CSHCN unique services. The second shift occurred during that same year, with enabling services increasing from 15% in 1998 to 25% in 1999 to a high of 56% in 2000. This service expenditure has been gradually decreasing since 2000, to the current level of 38% in 2006. The reason for this dramatic increase was the need for the health care system to absorb the dramatic shift in services. Many local health departments were initially reluctant to turn over all care coordination to the newly formed Managed Care Organizations (MCO). This concern has decreased as MCO case management has been instituted and a formal communication system has been established. Most of the current funding for these services has been in prenatal and early infant home visiting of the families most at risk for poor maternal and birth outcomes. The last shift has occurred as the State Title V Agency has educated and notified local health departments that combined, the majority of Title V dollars should be allocated for population-based services and infrastructure development.

While dialogue began in 2000 during the last Title V Needs Assessment, it wasn't until FY 2002 that a significant shift began to occur. As a percentage of total federal expenditures, population-based services moved from 5% in 2001 to 10.7% in 2006, and infrastructure-based services shifted from 28% in 2001 and to 43% in 2006. This resulted in the continual decline of direct service dollars to a low of 9.8% in 2006.

***//2009/ Maryland received a \$120,758 reduction in federal Title V funds between FY 2007 (\$12,044,593) and FY 2008 (\$11,923,835). Between FY 2008 and FY 2009 (\$11,931,558), there was a slight increase of \$7,723 in Title V Block Grant funding. As a result of this reduction, the Maryland Title V cut is no longer able to cover the costs of services provided by a perinatologist (\$75,000) at a local hospital. The loss of funding also resulted in the elimination of a Crenshaw Perinatal Health grant to a Southern Maryland county. This grant supported the Southern Maryland Perinatal Partnership, a regional partnership that provided enabling services in several counties.***

***In addition to the federal cuts, State budget cuts in the of approximately \$350,000 resulted in cuts to local health departments for lead outreach and case management services for***

***FY 2009. These cuts in affected the provision of enabling services to the Title V population group of children ages 1-22. The State has set a goal of eliminating new cases of childhood lead poisoning by 2010. //2009//***

## **B. Budget**

The Maternal and Child Health Program budgets and functions reflect an evolving public health responsibility that complements and enhances the current health delivery system, recognizes recent legislative changes in health and mandated public health functions, the uniqueness of the populations being served, and emerging research and standards of care affecting the health status of MCH populations. Maryland's Title V budget for FY 2008 totals \$21,352,904 including \$12,045,757 in federal funds and \$9,307,147 in State funds and reflects an expected decrease in federal block grant funding.

***/2009/ Maryland received a \$120,758 reduction in federal Title V funds between FY 2007 (\$12,044,593) and FY 2008 (\$11,923,835). Between FY 2008 and FY 2009 (\$11,931,558), there was a slight increase of \$7,723 in Title V Block Grant funding. As a result of this reduction between 2007 and 2009, the Maryland Title V cut is no longer able to cover the costs of services provided by a perinatologist (\$75,000) at a local hospital. The loss of funding also resulted in the elimination of a Crenshaw Perinatal Health grant to a Southern Maryland county. This grant supported the Southern Maryland Perinatal Partnership, a regional partnership that provided enabling services in several counties.***

***In addition to the federal cuts, State budget cuts in the of approximately \$350,000 resulted in cuts to local health departments for lead outreach and case management services for FY 2009. These cuts in affected the provision of enabling services to the Title V population group of children ages 1-22. The State has set a goal of eliminating new cases of childhood lead poisoning by 2010. //2009//***

Maryland continues to allocate Maternal and Child Health Block Grant funds using criteria that include: (1) MCH priority needs based on statewide and community assessments, (2) local health department fiscal shortfalls within the identified core categories, (3) poverty rates and estimated size of the maternal and child population (birth-21 years of age), (4) performance measures and outcome measures and (5) the availability of other funding sources. An example of this is the MCHP expansion which enabled funds to be reallocated from direct services for CSHCN to other population groups ineligible for MCHP. Funds may be reallocated throughout the year when unexpected needs are identified. (Budgets are developed two years prior to authorized spending. For example during the summer of 2006, the MCH Budgets for FY 2008 were developed. During the 2007 Legislative Session, the FY 2008 budget was approved).

***/2009/ Throughout the development and subsequent expenditure of the MCH budget, the grant is fiscally and programmatically monitored to ensure that the funding levels adhere to the "30-30-10" Title V requirement. For FFY 2009, it is proposed that funding for each Title V population will be distributed accordingly: Preventive and primary care for children -- 47%, CSHCN --38% and Administration -- 3%. The other category at 12% refers to maternal and infant health population. In addition, throughout the two-year process, but particularly during the budget development and the revision phase (based on legislative authorized budget), the MCH Offices evaluate the MCH Service Pyramid fiscal allocation to ensure that it reflects the spirit and intent of MCHB. //2009//***

Throughout the year, quarterly meetings are held between the MCH Offices and the Budget Personnel to determine current expenditure levels and expected expenditure for the remainder of the year. It is during these meetings that budget shortfalls and funds to be reallocated are identified. Throughout the year all contracts including LHD grants are tracked through the procurement process and subsequently monitored for appropriate and timely expenditures, and adherence to DHMH fiscal procedures.

The State share in MCH services is considerable, and more than meet the requirements for the State match. State appropriations dedicated to MCH related activities include early intervention services, immunizations, mental health and family planning services. Federal sources of MCH related dollars other than the block grant include early intervention, Part C; Centers for Disease Control and Prevention (immunizations and the public health infrastructure); abstinence education; family planning; WIC; HIV/AIDS; and SSDI (community assessments, enhancing data and epidemiological capacity). Maryland meets the maintenance of effort requirement of Sec. 505 (a)(4).

***//2009/ For FFY 2009, federal Title V funds in the amount of \$1,377,908 //2009//*** will be allocated for programs and services for women and infants. These funds will be administered through the Maternal and Perinatal Health Program and will support infrastructure level activities, through the Improved Pregnancy Outcome Program (IPO) and the Crenshaw Perinatal Health Initiative, to improve pregnancy and birth outcomes. IPO funds are provided to each local health department to support FIMR and other activities. Crenshaw funds are competitively awarded to local health departments to support innovative strategies. Funds will also partially support promotion of breastfeeding, education about perinatal depression, and support for identification and prevention of fetal alcohol spectrum disorders (FASD).

Title V will also support local health department based home visiting and care coordination services for pregnant women and infants as well as other activities aimed at improving the health of pregnant women and infants including standards development, quality assurance, health promotion and outreach. Preventive and primary care services for pregnant women and children are administered by the Center for Maternal and Child Health. In addition, newborn screening activities are carried out by the Office for Genetics and CSHCN. Newborn Screening includes two major programs. The Newborn Screening Program screens newborns for 32 disorders that may cause mental retardation and/or serious medical problems unless treated soon after birth. The Universal Infant Hearing screening Program provides for early identification and follow-up of hearing impaired infants and infants at risk for developing a hearing impairment.

***//2009//The Newborn Screening Program now screens newborns for all the disorders recommended by the American College of Medical Genetics , the American Academy of Pediatrics and the March of Dimes including the secondary targets, over 54 disorders. //2009//***

***//2009/ In FFY 2009, a total of \$5,633,869 //2009//***in federal funds are budgeted to support programs and services for children and adolescents. Funds will be awarded to local health departments to support a broad range of activities to improve the health of children and adolescents. Activities include home visiting, care coordination, child fatality review, school health, health screenings, immunizations, and health education/outreach. Funds will also be used to administer the Childhood Lead Screening Program to include promotion of increased blood lead testing in 20 of the state's 24 jurisdictions, and outreach and education to increase lead awareness. Grantees include local health departments, universities, and the Maryland Coalition to End Childhood Lead Poisoning. CMCH will use these funds to support programs and activities concerned with school and adolescent health, asthma education and outreach, childhood nutrition and obesity issues, and SIDS counseling, outreach and education.

***//2009/ The FFY 2009 budget includes \$4,575,995 //2009//***in federal funds only to support programs and services for CSHCN. These activities and programs will be administered by the Office for Genetics and Children with Special Health Care Needs. Direct care services to be funded include payment of specialty care for uninsured and underinsured CSHCN as well as two medical day care centers for medically fragile infants and young children. Funding will go to local health departments, Parent's Place of Maryland, and University Centers of Excellence for enabling services such as information and referral, care coordination/wrap-around services, and a

variety of respite activities. Population-based services funded will include the newborn screening follow-up accomplished through the Office. Specialty medical centers and some local health departments will also receive funding to support specialty clinic infrastructure, with particular emphasis on neurodevelopmental, genetic, and hematologic services.

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.